Open Book
Learning from close calls and adverse events

Preventing retained items – gynaecology surgery

This report aims to alert providers to the key findings of a recent review, 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
- midwifery services.

Incident

A patient had a gynaecology procedure that included the insertion of a vaginal pack, to be removed the following day. When the pack was removed, a Raytec surgical swab was also discovered.

Chronology

- A patient underwent an elective gynaecology procedure, at the end of which a vaginal pack was inserted for removal the following day. The final theatre count did not identify any missing items.
- When the pack was removed the following day, the nurse noticed and removed a Raytec swab that had been unintentionally retained.

Findings

- The final count in theatres was generally done before the end of the procedure – the vaginal skin had not been completely closed, and the vaginal pack and urinary catheter were still to be inserted.
- Occasionally, gauze swabs would still be used after the final count to clean the surgical area or on bleeding spots.
- The review concluded that a Raytec swab was used after the final count, and therefore its retention was not noticed.

Actions subsequently taken

The surgical count procedure document has been amended to include the following:

- The final count is not to occur until completion of skin closure.
- For gynaecology procedures requiring vaginal packs, the final count is to occur after the insertion of the vaginal pack.

Health Quality & Safety Commission comment

- It is possible that, in other procedures, materials may be used after the final count, while there is still a risk they may be inadvertently retained. Theatre staff should ensure there are adequate systems to prevent this occurring.
- The World Health Organization's guidelines for safer surgery (2006) make recommendations on how to prevent the inadvertent retention of instruments and swabs in surgical wounds.[1] The recommendations include:
  - a full count to be performed when the peritoneal, retroperitoneal, pelvic or thoracic cavity is entered
  - counts to be done for any procedure in which equipment or items such as swabs could be retained in the patient, with the counts to be performed at least at the beginning and end of every eligible case
  - counts to be recorded, and the results clearly communicated to the surgeon.

[1] www.who.int/patientsafety/safesurgery/tools_resources/9789241598552/en/

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