

Manitoba Health, Healthy Living & Seniors (MHLS) supports reporting and learning from patient safety events. The focus of a patient safety review is to closely look at the health care system that surrounds and interacts with those giving and receiving care. The goal is to identify risks to patient safety and recommend the most effective ways to minimize risk and improve the delivery of healthcare.

Patient Safety Learning Advisory

Retention of a foreign body in a patient after surgery

Summary:

A patient was scheduled for a Laparoscopic Supracervical Hysterectomy (LSH) which is the removal of the upper part of the uterus leaving the cervix through multiple tiny incisions. During the laparoscopic procedure it was noted that the metal part of the suture (needle) came apart from the string. Numerous attempts to retrieve the needle were executed with no success. A decision was made by both operating room (O.R.) surgeons at the time to leave the foreign body in the patient's peritoneal cavity and proceed with the completion of the surgery. The patient was later informed in the recovery room about the event and an apology was provided. The patient had to undergo a second surgery at a later date of one month post event in order to retrieve the foreign body.

Keywords: Foreign body retention

Device Name (if applicable):

Drug/Name/Fluid Name: (if applicable):

Type of Analysis: single event

Topic: Surgery

Findings of the Review:

The procedure Laparoscopic Supracervical Hysterectomy (LSH) has an inherent risk of needle separation during the process of removal through a trocar that increased the likelihood that a needle could separate at the juncture.

The position of the patient combined with the environmental layout of the O.R. theatre coupled with the incompatibility of the C-Arm not being able to fit underneath the O.R. table didn't allow for the C-Arm fluoroscopy to visualize the location of the needle therefore increased the likelihood that the needle could not be retrieved.

System Learning:

Explore the option of a larger trocar size and/or a smaller suture needle for laparoscopic procedures to minimize the risk of needle suture separation related to the task at hand of pulling the suture through the trocar.

Implement the findings i.e. increasing the trocar size and/or a smaller suture needle.

Integrate the regional process for purchasing new and/or replacement equipment at all regional surgical centres to include and not be limited to the following: Completion of an environmental scan to ensure compatibility of diagnostic equipment, i.e. C-Arm in combination with scope of surgical practices/procedures being performed at the site.

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