13-Inch Surgical Tool Left In Patient for Months

For about two months after surgery to remove a large malignant tumor Donald Church complained of severe pain. Initially, he was told that it was normal pain associated with recovery from a major surgery, but an x-ray was ordered after his physician felt a lump in his abdomen. The x-ray revealed that a malleable retractor similar in size to a ruler had been left inside his body after surgery. A second surgery was done to remove the tool. Mr. Church is not expected to suffer from long term health consequences and received a $97,000 settlement.

1 Problem

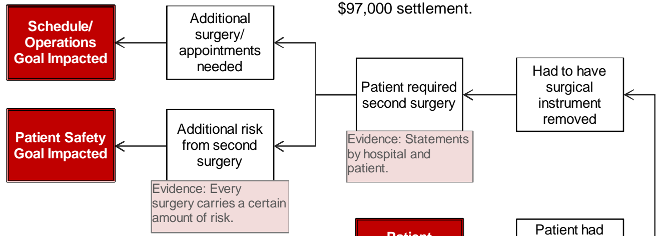
What	Problem(s)	Tool left in patient after surgery
When	Date	June 1, 2000
	Different, unusual, unique	??
Where	Facility, site	University of Washington Medical Center
	Unit, area, equipment	Operating room
	Task being performed	Removal of a large malignant tumor

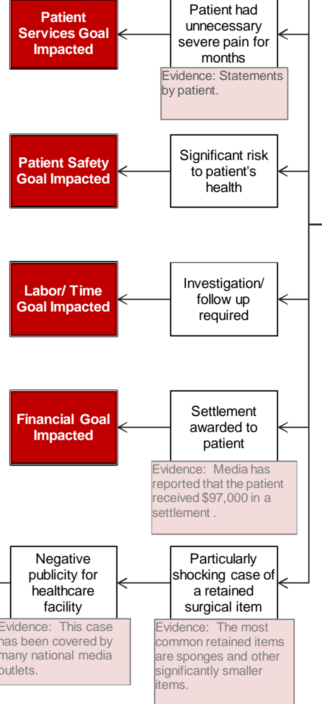
Impact to the Goals

Patient Safety	Significant risk to patient's health
	Additional risk from second surgery
Patient Services	Patient had unnecessary severe pain for months
	Negative publicity for healthcare facility
Schedule/ Operations	Additional surgery/appointments needed
Financial	Settlement awarded to patient
Labor/ Time	Investigation/ follow up required

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

2 Analysis





Had to have surgical instrument removed

Patient had unnecessary severe pain for months

Evidence: Statements by patient.

Significant risk to patient's health

Investigation/ follow up required

Settlement awarded to patient

Evidence: Media has reported that the patient received $97,000 in a settlement .

Patient Services Goal Impacted

Particularly shocking case of a retained surgical item

Evidence: The most common retained items are sponges and other significantly smaller items.

Large surgical instrument left in patient after surgery

Evidence: X-ray taken 2 months after initial surgery showed a 13 inch malleable retractor.

Effect ← Cause

Solution:

Evidence:

Patient underwent surgery ← Removal of a large malignant tumor

Evidence: Statements by hospital and patient.

AND

Tool was used during surgery ← Used to protect organs while wound is being closed ← Organs could be punctured by suturing needle

AND

Surgeons were unaware tool remained in patient

Evidence: Tool would have been removed if its presence in body was known.

Couldn't see the tool

Normally held partly out of the would opening

AND

Slipped completely inside the wound ← ?

AND

Inadequate management of surgical tools

Surgical tool was lost

AND

No requirement to count surgical instruments ← ?

3 Solutions

A simple solution to reduce the risk for retained surgical items is to institute a formal procedure for counting surgical supplies and tools before and after surgery. Simple manual counts are a decent first step, but errors still occur, especially in the often hectic and stressful environment in an operating room. Some hospitals use a visual inventory system where tools are brought in a special storage bag with an individual compartment for each item. As items are done being used they are put back into their specific spot. If all compartments are full, everything is accounted for so it's easy to tell if something is missing. Another solution that is gaining in popularity is use of an electronic tracking system. The most common use of electronic systems is to track sponges, which are by far the most common object left inside patients. Each sponge has an electronic tag and the patient is scanned after surgery to verify that none were left behind. The sponge tracking systems add about $8 to $12 to the cost of each surgery and have dramatically reduced the number of retained sponges when used.

CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis

Step 1	Problem	What's the Problem?
Step 2	Analysis	Why did it happen?
Step 3	Solutions	What will be done?

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