



مستشفى الملك فيصل التخصصي ومركز الأبحاث  
King Faisal Specialist Hospital & Research Centre

# QUALITY & SAFETY COMMITTEE MEETING #22

Monday, 20 February 2023  
(3:30 - 5:30 pm)





## Patient Safety Story - Retained Surgical Object

Latfia is a 54-year-old female diagnosed with Squamous Cell Carcinoma who had a previous left partial glossectomy and neck dissection. She had a repeat partial glossectomy, with left neck node excision, right modified neck dissection, free flap, and skin grafting. The patient was discharged home with a tracheostomy after 14 days of hospitalization.

One week after discharge, while the family was suctioning the tracheotomy tube, Latfia vomited a 4x4 gauze that was left in the patient's throat. The family contacted the tracheostomy specialist, who advised them to go to the emergency. Latfia had no further problems afterwards.



## Patient Safety Story - Cont.

### Findings:

- It was normal agreed practice that responsibility for the throat packs is assigned to the anesthesiology department however in this case the throat pack was placed by ENT,
- The nurse had a concern about the throat pack number and count but the physician did not respond and the nurse did not escalate. (On further deep dive, there was a feeling of absence of a collaborative culture, as well the presence of a power gradient in the peri-operative areas”),
- Lack of compliance with the established counting policy and Procedures including announcement of the removal of throat pack, white board count, paper count, etc..
- The appropriate throat pack (with pull cord) has not been available for one year. Therefore staff have been using alternatives solutions such as using non radio-opaque gauze without a cord.

### Lessons Learned:

- Emphasize the collaborative culture and communication in the Multidisciplinary Teams,
- Ensure utilizing the universal skill STAR (Stop, Think, Act, & Review) and Stop the line,
- Ensure compliance with the established policy.