Patient Safety Learning Advisory

Patient Safety Event: Retained Surgical Sponge

Why was this a Critical Incident?

As per “Never Events for Hospital Care in Canada”, a sponge or a towel left inside a patient after surgery are never events regardless of whether harm occurred or not, or whether the object was discovered in hospital or after discharge. The event met critical incident criteria due to the retention of a foreign body in a patient after surgery or procedure, causing the patient to seek care on a number of occasions and treatment for infection and a delay in wound healing

What happened in the incident?

A patient had a minor procedure (lipoma removal) on October 30, 2024. They started having symptoms of infection (pain and redness) in the surgical area and was prescribed antibiotics on November 6th and 13th for same. The patient continued to experience pain and drainage from the wound over the next few weeks, and presented to a walk-in clinic on November 20th. The physician noted a small open area and packed the wound with a small piece of gauze, and the patient was instructed to return to the Home Care Treatment Clinic for dressing changes.

The patient was seen at the wound care clinic on November 26th where the nurse noted a small white foreign body in the open wound. A 25cm by 12 cm gauze (surgical sponge) was removed from the wound, along with copious amounts of drainage.

What is the Health Care System learning?

A 4cm by 4cm gauze was inadvertently left in the wound, and the wound was sutured closed after the lipoma removal on October 30th.

The emergency department (ED) is frequently used for outpatient procedures, such as this one.

Due to the nature of the emergency department (volume of patient presentations, ongoing staffing concerns and a fragile balance of same) having nursing support present for small outpatient procedures is not feasible.

What are the recommendations?

There are no recommendations following the critical incident review as the event was an isolated practice issue and no system changes are evident.

Keywords: Retained Surgical Sponge

Your privacy is important to us, so in this summary we have removed any details which would help identify the subject of this event. It's important that we can learn from safety events and make changes to improve the care we provide.