Health NZ breached Code after surgical swab retained inside woman after surgery
22HDC00014

The Health and Disability Commissioner has found Health New Zealand | Te Whatu Ora Counties Manukau (Health NZ) breached the Code of Health and Disability Services Consumers' Rights after a surgical swab was retained inside a woman's vagina following surgery.

The woman had an elective laparoscopy, bilateral salpingectomy, and total hysterectomy at the Manukau Super Clinic hospital. She was discharged home two days later following an 'uncomplicated recovery'.

After a few days the woman noticed she had abnormal vaginal discharge and experienced lower abdominal pain, hot flushes, and a reduced appetite. She presented to an urgent care clinic, where she was given antibiotics. The pain worsened overnight, so she called Healthline which advised her to go straight to the hospital.

During an examination at the hospital, the gynaecologist found and removed a surgical swab that had been retained inside the woman's vagina. The woman was re-admitted to hospital for observation, was given antibiotics and had an abdominal X-ray to exclude any further foreign bodies.

Health NZ told HDC that the surgical count during the women's surgery (including swabs) was completed and documented as correct. The count sheets for both the top and bottom trolleys show that a collective total of 40 small swabs and five large swabs were used during the procedure.

Dr Vanessa Caldwell, Deputy Health and Disability Commissioner found that at some point in the surgery, a swab was placed into the woman's vagina and not accounted for.

"I consider this to be a clear demonstration of a systems failure, in that the surgical count process, which is designed to ensure that all surgical items used during a procedure are removed and accounted for, clearly failed in this instance."

Dr Caldwell said the incident highlights the need for hyper-vigilance during surgery, and the importance of strict adherence to surgical count policies and processes. She found Health NZ (Te Whatu Ora Counties Manukau) in breach of the woman's right to have services provided with reasonable care and skill.

Dr Caldwell said she was encouraged by Health NZ's prompt response and apologies to the woman, and thorough review of events by way of its adverse event review.

"Clearly, this event has been taken extremely seriously, with all surgeons and theatre teams being educated about the case. I note that several changes and recommendations have been made since this event to reduce the possibility of such an incident reoccurring."

Dr Caldwell made a number of recommendations for Health NZ which are outlined in the report and include performing a random audit of 20 patients' records from the past three months and conducting training for staff on the Count Policy.

8 July 2024

Editor's notes

Please only use the photo provided with this media release. For any questions about the photo, please contact the communications team.

The full report of this case can be viewed on HDC's website - see HDC's 'Latest Decisions'.

Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code unless it would not be in the public interest or would unfairly compromise the privacy interests of an individual provider or a consumer. More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2022/23 HDC made 592 quality improvement recommendations to individual complaints and we have a high compliance rate of around 96%.

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