

**Dr Jim Livingstone**  
Director of Safety, Quality and Standards



Department of  
**Health, Social Services  
and Public Safety**

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

AN ROINN  
**Sláinte, Seirbhísí Sóisialta  
agus Sábháilteachta Poiblí**

MÁNNYSTRIE O  
**Poustie, Resydènter Heisin  
an Fowk Siccar**

## **SAFER PRACTICE NOTICE**

**Subject:**

**Reducing the risk of retained throat packs after surgery**

**For action by:**

SABS Liaison Officers:

- to acknowledge receipt by 28 May 2009
- to indicate action underway by 31 July 2009
- to confirm completion by 14 November 2009

Chief Executives, HSC Trusts

Medical Directors, HSC Trusts, for cascade to:

- *Associate Medical Directors*
- *Clinical Directors*
- *Heads of Governance*
- *Consultant surgeons*
- *Consultant anaesthetists*

Directors of Nursing, HSC Trusts

Chief Executive RQIA for cascade to:

- *Independent hospitals and clinics*

**For Information to:**

- Chief Executive, HSC Board
- Chief Executive, Public Health Agency
- Director of Public Health, Public Health Agency
- Director of Nursing, Public Health Agency
- Professor David Woolfson, Head of School of Pharmacy, QUB
- Professor Linda Johnston, Head of Nursing & Midwifery, QUB
- Professor Hugh McKenna, Head of Life and Health Sciences, UU
- Dr Owen Barr, Head of School of Nursing, UU
- Staff Tutor of Nursing, Open University
- Director, Safety Forum

**Summary of Contents:**

The purpose of this Circular is to highlight recommended solutions to reduce the risk from unintended retention of throat packs after surgery.

**Enquiries:**

Any enquiries about the content of this Circular should be addressed to:

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**Circular Reference: S&Q Learning Communication 06/09**

**Date of Issue: 22 May 2009**

**Related documents**

HSS (MD) 18/2009: Safe Surgery Saves Lives  
<http://www.dhsspsni.gov.uk/hss-md-18-2009.pdf>

**Superseded documents**

N/A

**Status of Contents:**

For implementation

**Implementation:**

Ongoing

Dear colleagues

**SAFER PRACTICE NOTICE (S&Q LEARNING COMMUNICATION 06/09): REDUCING THE RISK OF RETAINED THROAT PACKS AFTER SURGERY**

Following identification of a number of incidents, the National Patient Safety Agency has issued a Safer Practice Notice highlighting recommended solutions for reducing the risk to patients from the unintended retention of throat packs following surgery.

The content of the attached Safer Practice Notice at Annex A has been reviewed by relevant professional colleagues in the Department and approved for regional dissemination.

I would ask you to bring this to the attention of relevant practitioners and key health and social care staff within your organisation. They should consider the best practice for their setting and take appropriate steps to minimise the risk to their patients of a similar incident.

Yours sincerely

***[SIGNED]***

**Andrew Browne**

on behalf of

**Dr J F Livingstone**

Director, Safety, Quality & Standards

## **SAFER PRACTICE NOTICE (S&Q LEARNING COMMUNICATION 06/09): REDUCING THE RISK OF RETAINED THROAT PACKS AFTER SURGERY**

Your attention is drawn to NPSA SAFER PRACTICE NOTICE NPSA/2009/SPN001: Reducing the risk of retained throat packs after surgery.

Throat packs are often inserted by anaesthetists or surgeons to absorb material created by surgery in the mouth, prevent fluids or material entering the oesophagus or lungs, prevent escape of gases from around tracheal tubes, and/ or stabilise artificial airways.

### **Recommended Solutions**

In response to concerns about the potential risk to patients from the unintended retention of throat packs after surgery, the following solutions are recommended to reduce risk:

#### Procedures involving visual checks

- Label or mark patient:
  - either on the head;
  - or, exceptionally, on another visible part of the body with an adherent sticker or marker.
- Label artificial airway (for example tracheal tube or supraglottic mask airway).
- Attach pack securely to artificial airway.
- Leave part of pack protruding.

#### Procedures involving documentary checks:

- Formalised and recorded 'two-person' check of insertion and removal of pack.
- Record insertion and removal on swab board.

The decision to use a throat pack should be justified by the anaesthetist or surgeon for each patient as appropriate, and this person should assume responsibility for ensuring safety procedures are undertaken. It is recommended that at least one visually-based and one documentary-based procedure is applied whenever a throat pack is deemed necessary and that all relevant staff are informed on the locally chosen procedures.

### **WHO Surgical Checklist**

NPSA recommends the use of the WHO Surgical Safety Checklist that has been adapted for use in England and Wales. However, I would draw your attention to HSS (MD) 18/2009: Safe Surgery Saves Lives (<http://www.dhsspsni.gov.uk/hss-md-18-2009.pdf>), issued on 13 May 2009, which commends the use of the **unadapted** WHO surgical checklist for use by the HSC. As outlined in this earlier circular, the WHO checklist contains the core set of safety checks which may be added to locally as appropriate. You should therefore consider using the checklist when working with throat packs.

The NPSA Safer Practice Notice can be accessed in full at <http://www.npsa.nhs.uk/nrls/alerts-and-directives/notices/throatpacks/>