Retained foreign object post procedure

S	A urology patient was transferred from ICU to theatres for emergency laparotomy for what was believed to be life threatening haemorrhage. To aid resuscitation a large bore central venous catheter was inserted into the patients internal jugular vein. An x-ray to confirm catheter position taken on return to ICU revealed the presence of the guide wire.
B	The patient was transferred to theatre at evening handover under the care of anaesthetic Consultant 1. The care of the patient was taken over by Consultant 2 and a trainee. All three anaesthetists continued to provide care for the patient whilst set up for surgery took place. Consultant 1 undertook to insert the central venous access but also provided anaesthetic care for the patient supporting Consultant 2. Consultant 1 was supported by an anaesthetic assistant to insert the access line. At the end of the procedure the rubbish was cleared away rapidly to facilitate ongoing care. There was no checking procedure in place to ensure the guide wire had been removed.
A	Root cause: There was no procedure in place for ensuring that the guide wire had been returned to the trolley prior to disposal of rubbish. Contributory Factor: Although communication between the two Consultants occurred there was no clear division of duties. This resulted in Consultant 1 becoming distracted when the patients' blood pressure reduced.
R	Learning: Clear delegation of responsibilities between the two Consultants would have allowed Consultant 1 to focus on the task of line insertion without distraction A checking procedure to ensure that the guide wire and other disposable items had been identified prior to disposal of rubbish would have identified the retained wire prior to use of the catheter. Recommendations: A LocSIPP for insertion of venous and arterial catheters using a Seldinger (catheter over wire) technique must be developed and introduced. Human factors training for anaesthetists should include team management in emergency situations