Trust Standard Operating Procedure

Standard Operating Procedure: Throat Pack Use in Theatre

Issue Date	Review Date	Version
10th April 2018	April 2023	V2

Purpose

To provide guidance for the insertion and removal of throat packs

Who should read this document?

All theatre personnel within Plymouth Hospitals UPHNT Trust and including Tavistock Theatres

Key Messages

To ensure safe practice when using a throat pack
To ensure the removal of the pack postoperatively

Core accountabilities	
Owner	Michelle-Jane Smith – Matron
Review	Theatre policy Committee
Ratification	Clinical Governance Lead
Dissemination	Cindy McConnachie - Senior Matron Theatres and Anaesthetics – Quality, Governance and Strategy , Project Lead NatSSIP's
Compliance	Theatre Policy Committee

Links to other policies and procedures

Swab Counts in Theatre Policy

Version History

V2	10th April 2018	Revised in to new template

The Trust is committed to creating a fully inclusive and accessible service. Making equality and diversity an integral part of the business will enable us to enhance the services we deliver and better meet the needs of patients and staff. We will treat people with dignity and respect, promote equality and diversity and eliminate all forms of discrimination, regardless of (but not limited to) age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage/civil partnership and pregnancy/maternity.

An electronic version of this document is available on Trust Documents on StaffNET. Larger text, Braille and Audio versions can be made available upon request.

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the Trust. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

Plymouth Hospitals NHS
NHS Trust

Standard Operating Procedure (SOP)

Throat Pack Use in Theatre

1 Introduction

To provide a standard process for the insertion and removal of throat packs

2 Definitions

To ensure safe practice when using a throat pack to reduce the risk of blood and secretions compromising the airway.

To ensure the removal of the pack postoperatively

3 Regulatory Background

Provide a brief description of the key legislation, regulation and policy on which this procedural document is based.

National patient Safety Agency (2009), Reducing the Risk of Retained Throat Packs after Surgery. Safer Practice NoticeNPSA/2009/SPN001

4 Key Duties

All throat packs used during surgery are part of the swab count and must be recorded on the swab board.

At least **2 methods of visual and 1 method of documentary procedure** must be undertaken to prevent retention of the throat pack.

5 Procedure to Follow

Throat pack inserted by the Anaesthetist:

When ribbon gauze is used as a throat pack, the end to be inserted must be knotted to ensure identification of complete removal.

- After insertion the end of the throat pack should be taped to the cheek ortied to the endotracheal tube.
- If this is not feasible the rationale for this decision **must** be documented in the perioperative pathway by the anaesthetist.
- The throat pack is identified by a sticky label attached to one of three locations depending on the procedure undertaken (ETT dressings, forehead or ETT). A second throat pack sticker must also be placed on the pilot tube.
- The insertion must be recorded by the anaesthetist in the Perioperative Integrated Care Pathway
- The Anaesthetist Practitioner must:
    1. Inform the scrub practitioner verbally that a throat pack is in situ.
    2. The scrub practitioner must acknowledge this verbally.
    3. The use of a throat pack must be recorded on the swab board and included in the swab count.
- In the event of a change of anaesthetist the 2nd anaesthetist should countersign the insertion in the Perioperative Integrated Care Pathway document.

When a throat pack is inserted by the Surgeon:

- The Surgeon must ensure that both the scrub practitioner and Anaesthetist are aware of and verbally acknowledge that throat pack is in situ.
- The throat pack must be added to the swab board and included in the swab count as indicated above.
- If the surgeon inserts a throat pack during a procedure it may not be possible to use throat pack stickers.

Removal of the Throat Pack

Responsibility to ensure removal of the Throat Pack lies jointly with both Surgeon and Anaesthetist

- The throat pack is always removed prior to extubating and before the patient leaves theatre.
- Throat pack stickers must not be removed from the patient prior to removal of the throat pack
- Removal of intact throat pack must be verbally confirmed by the scrub practitioner and both the Surgeon and Anaesthetist.
- The removal of the throat pack must be confirmed by crossing it off on the white board.
- The removal of the pack must be recorded in the Perioperative Integrated Care Pathway document.
- Use and removal of the throat pack should be handed over to the recovery staff.

6 Document Ratification Process

The design and process of review and revision of this procedural document will comply with The Development and Management of Formal Documents.

The review period for this document is set as default of five years from the date it was last ratified, or earlier if developments within or external to the Trust indicate the need for a significant revision to the procedures described.

This document will be reviewed by the Theatre policy Committee and ratified by the Director Lead.

Non-significant amendments to this document may be made, under delegated authority from the Clinical Governance lead, by the nominated author. These must be ratified by the Clinical Governance lead and should be reported, retrospectively, to the Theatre policy Committee

Significant reviews and revisions to this document will include a consultation with named groups, or grades across the Trust. For non-significant amendments, informal consultation will be restricted to named groups, or grades that are directly affected by the proposed changes.

7 Dissemination and Implementation

Following approval and ratification, this procedural document will be published in the Trust's formal documents library and all staff will be notified through the Trust's normal notification process, currently the 'Vital Signs' electronic newsletter.

Document control arrangements will be in accordance with The Development and Management of Formal Documents.

The document author(s) will be responsible for agreeing the training requirements associated with the newly ratified document with the Director Lead and for working with the Trust's training function, if required, to arrange for the required training to be delivered.

8 Monitoring and Assurance

The band 7 staffs are responsible for implementation and compliance across their teams.

Breaches of the policy are to be recorded as incidents using the Trust Incident Reporting process

Regular review of any incidents relating to this policy which may indicate non-compliance

- The Senior (Band 7) staff is responsible for the implementation and compliance across their teams.
- The use of audit tools to randomly monitor the staffs' understanding of selected policies
- Breaches of this policy are to be recorded as Incidents using the Trust Incident Reporting process

9 Reference Material

- National patient Safety Agency (2009), Reducing the Risk of Retained Throat Packs after Surgery. Safer Practice NoticeNPSA/2009/SPN001
- Association for Perioperative Practice (2007) AfPP Standards and Recommendations for Safe Perioperative Practice. Harrogate, Association for Perioperative Practice.

Checklist for the Review and Approval of this policy			Appendix 1
	Title of document being reviewed:	**Yes/No/ Unsure**	**Comments**
1.	**Title Style & Format**		
	Is the title clear and unambiguous?	Yes	
	Does the Style & Format comply with Trust Policy?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	E-mails kept within the Group
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	N/A	

6.	**Approval & Ratification**		
	Does the document identify which committee/group will approve and ratify it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	Audits to be developed within theatre
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Committee Approval			
If the Committee approves this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	

Signature			
Clinical Governance Group Approval			
If the group approves this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Clinical Governance Steering Group?	Date	*2013?*
Signature			

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust