Theatre incident resulting in corneal burns (06HDC00096, 29 June 2006)

Plastic surgeon ~ Private hospital ~ Eye-shields ~ Corneal burns ~ Safe operating theatre environment ~ Adverse event ~ Incident reporting ~ Open disclosure ~ Vicarious liability ~ Rights 4(1), 4(2), 4(4), 4(5), 6(1)

A 51-year-old woman had cosmetic eyelid surgery performed by a plastic surgeon at a private hospital. The woman complained about the adequacy of the surgical services provided by the plastic surgeon and the hospital as well as the theatre systems at the hospital.

It was the practice of the plastic surgeon to cover the eyeballs with plastic eye-shields to prevent damage to the cornea during surgery to the lower lids. Hospital staff sterilised the eye-shields with a solution of chlorhexidine 0.5% in 70% spirit. It was the hospital's practice to soak the eye-shields in the solution in a bowl in the preparation room. The circulating nurse would then bring the bowl into the theatre and place the unrinsed eye-shields into a gallipot on the sterile equipment trolley before returning to the preparation room for sterile water to rinse the eye-shields before use. In this case the surgeon took the eye-shields and placed them in the patient's eyes before the solution was rinsed off. The theatre assistant told the surgeon about the error, and he removed the shields, rinsed the woman's eyes and examined the cornea for injury. Being assured that no injury had occurred, the surgeon completed the surgery. He did not report the matter in his notes, or to theatre and recovery room staff, or to the patient. The theatre staff did not record the incident as an "adverse event".

On awakening from surgery the woman suffered excruciating pain, which was not relieved with additional analgesia. The following morning another doctor arranged for her to see an ophthalmologist, who diagnosed abrasions to both corneas caused by the chemical solution. He informed the plastic surgeon. The woman's condition worsened but the surgeon did not enquire into her welfare or disclose what had occurred in theatre.

Two weeks after the surgery, the woman had developed corneal ulcers with possible nerve damage, and had remained in considerable pain. She made a complaint to the private hospital and, following its investigation, was told that her corneal ulcers were the result of the soaking solution.

It was held that the plastic surgeon breached Rights 4(1) and 6(1) in failing to check the patient in the recovery room or tell her what had happened in theatre, and in managing her postoperative care inappropriately. The surgeon also breached Rights 4(2) and 6(1) in failing to document the event or discuss the matter with the ophthalmologist. Surgeons should have a very low threshold for incident reporting.

It was also held that the hospital did not take appropriate steps to minimise the harm posed by the sterilisation technique. In failing to provide a safe environment for the surgery, the hospital breached Right 4(4). Had the plastic surgeon known about the composition of the solution, it is most unlikely that he would have placed the eye shields in the woman's eyes. The lack of communication between theatre staff and the plastic surgeon about those risks therefore constituted a breach of Right 4(5) on the part of the hospital. Incident reporting policies were in place but, on this occasion, they were not followed by the staff involved with the surgery. In these circumstances

the hospital failed to follow its own “relevant standards”, and thereby breached Right 4(2). The private hospital was not held vicariously liable for the plastic surgeon’s breach.