Gynaecologist, Dr B
Medical Centre

A Report by the
Health and Disability Commissioner

(Case 17HDC02250)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. On 26 January 2017, Ms A underwent a hysteroscopy,[1] dilation and curettage[2] with a polypectomy,[3] insertion of a Mirena,[4] and marsupialisation[5] of a Bartholin's cyst.[6] Dr B, a consultant gynaecologist, performed the surgery at a medical centre's onsite theatre. The circulating nurse was Registered Nurse (RN) D, and the scrub nurse was RN C, both of whom worked at the medical centre.

2. The Count Policy at the medical centre stated that the count process is a delegated medical duty. During Ms A's surgery:

- An initial count was not completed. Only a partial initial count was performed by RN D and RN C.
- During the surgery, despite RN D hearing Dr B announce the insertion of a gauze swab, she neither communicated this to her colleague, RN C, nor recorded it herself.
- A closing count was not completed by RN D and RN C at the end of the surgery.
- As the count is a delegated medical duty, the surgeon was required to "verbally acknowledge the status at the end of the procedure". Dr B did not confirm the status of the count before leaving the surgery.

3. A gauze swab was retained in Ms A's operation site, and was discovered four days after the surgery.

Findings

4. The Commissioner found that communication was ineffective or non-existent at key points of the surgery, staff did not work together as an effective team, the Count Policy lacked detail, and staff members were non-compliant with the Count Policy. For these reasons, the medical centre did not provide services to Ms A with reasonable care and skill, and breached Right 4(1)[7] of the Code of Health and Disability Services Consumers' Rights (the Code).

5. The Commissioner also found Dr B in breach of Right 4(1) of the Code. Whilst there were wider systemic issues relating to communication and teamwork at play, Dr B accepted that ultimate responsibility lay with her as the surgeon, and that she should have checked that the gauze swab had been removed.

[1] Visual instrumental inspection of the uterine cavity.
[2] A procedure to remove tissue from inside the uterus.
[3] Removal of polyps.
[4] An intrauterine device used for contraception or heavy menstrual bleeding.
[5] Opening the cyst and sewing the edges to the surrounding skin to form an open pouch to allow continued drainage.
[6] A cyst in the lubricating glands found at the opening of a woman's vagina.
[7] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

Recommendations

6. The Commissioner recommended that the medical centre provide a written letter of apology to Ms A for its breach of the Code; report back to HDC on the outcome of its consideration of implementing team briefings and debriefings before and after surgery; report on its use of the surgical safety checklist; and perform a random audit of patients to identify compliance with its Operating Room Count Policy and report to HDC the results and any changes made.

7. The Commissioner recommended that Dr B provide a written letter of apology to Ms A; review the medical centre's new Count Policy; present this case to her peers; and report to HDC her reflections on these events.

Complaint and investigation

8. The Commissioner received a complaint from Ms A about the services provided by Dr B and the medical centre. The following issues were identified for investigation:

- *Whether Dr B provided Ms A with an appropriate standard of care between 2016 and 2017.*
- *Whether the medical centre provided Ms A with an appropriate standard of care between 2016 and 2017.*

9. The parties directly involved in the investigation were:

Ms A	Consumer
Dr B	Provider/consultant gynaecologist
The medical centre	Provider

10. Further information was received from:

RN C	Provider/registered nurse
RN D	Provider/registered nurse

Information gathered during investigation

Introduction

11. This report discusses the surgical care provided to Ms A (51 years old at the time of these events) in 2017. In particular, it discusses surgery that took place in early 2017, where a surgical gauze swab[8] was inadvertently left inside the surgical site.

[8] Absorbent material used during surgery.

12. On 8 December 2016, Ms A presented to her doctor with continuous vaginal bleeding, urinary symptoms, and lower abdominal discomfort. A pelvic ultrasound performed on 9 December 2016 revealed an endometrial polyp,[9] a fibroid uterus,[10] and adenomyosis.[11] The doctor referred Ms A for specialist review.

13. On 21 December 2016, Ms A was seen by Dr B.[12] Dr B examined Ms A and found an enlarged uterus with fibroids and a 3cm left Bartholin's cyst. After discussion about the available management options, Ms A agreed to undergo a hysteroscopy, dilation and curettage with a polypectomy, insertion of a Mirena to control menstrual bleeding, and marsupialisation of the Bartholin's cyst. Surgery was booked for 26 January 2017.

Surgery on 26 January 2017

14. The medical centre has an onsite theatre.[13] Dr B performed Ms A's surgery at the onsite theatre on 26 January. The circulating nurse was RN D, and the scrub nurse was RN C.

15. RN D told HDC that her duties as the circulating nurse included counting the swabs and sharps (anything sharp used during a procedure, such as needles) before, during, and after the procedure, with the scrub nurse, and recording their use on the intraoperative record. RN C told HDC that her responsibilities as the scrub nurse also included counting the swabs and sharps and updating the count board during the procedure.

Initial count

16. The Count Policy sets out the "first count" procedure as follows:

> "1) This is performed prior to initial incision.
>
> 2) This is performed by the circulating nurse/scrub nurse verbally together identifying the items to be counted.
>
> 3) Swabs should be unwrapped and each one counted separately and the X ray marker identified.
>
> 4) Needles and packets should be counted and doubled ended sutures should be documented as doubled ended.
>
> 5) All blades and injection needles are to be counted.
>
> 6) Once each item is counted it must be documented on the count board[14] and in the intra-operative record[15]."

[9] A growth attached to the inner wall of the uterus.
[10] Non-cancerous growths in the uterus.
[11] A condition in which the inner lining of the uterus grows into the muscular wall of the uterus.
[12] Dr B is a consultant gynaecologist with an annual practising certificate from the Medical Council of New Zealand. Dr B is a fellow of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and a member of the Royal College of Obstetricians & Gynaecologists.
[13] Dr B sees private patients at her rooms at the medical centre.
[14] A count board is used to document items used during the procedure.
[15] Record of what occurred during a procedure.

17. The Count Policy also states: "Blades and injection needles are to be counted in all cases."

18. The intraoperative record has a section titled "count record — before and during". Under "gauze swabs", the numbers "5 + 10"[16] were documented. However, no other surgical items appear to be counted in this section of the record.

19. The medical centre stated that a formal first count was not recorded, but the gauze swabs were counted in.

During the procedure

20. The surgery commenced at approximately 1.15pm. The anaesthetist's report documented that during the procedure Ms A coughed and went into laryngospasm,[17] which was "controlled with a small dose of Suxamethonium[18] and endotracheal intubation[19]". The surgical recovery report also noted that the surgery was a "difficult procedure both surgical and anaesthesia".

21. The Count Policy outlines that 'during the procedure', "all swabs, needles, and blades given during the procedure must be counted and documented in the same way as the initial count".

22. Dr B reported that during the procedure, she removed a uterine polyp that caused bleeding. To manage this, she inserted a small gauze swab in the vagina to control the bleeding. She announced to theatre staff that a gauze swab had been placed in the vagina. The circulating nurse, RN D, told HDC that she recalled hearing Dr B announce that a swab had been inserted. However, RN D did not document this on the intraoperative record. The scrub nurse, RN C, told HDC that she did not hear Dr B, and therefore did not update the count board.

Closing count

23. The Count Policy's "closing count" procedure states:

> "1) The closing count is performed in the same way as the initial count.
>
> 2) The counted items are verbally counted by the scrub nurse and circulating nurse on the sterile trolley and then checked with the count board and intra-operative record.
>
> 3) Once the correct count is verified the surgeon is informed and verbal recognition should be expected."

24. The Count Policy also outlines that "the count is a delegated medical duty, therefore the surgeon must verbally acknowledge the status at the end of the procedure".

25. This is the only step the Count Policy required the surgeon to conduct.

[16] The Count Policy states that "the swabs are in groups of 10, larger swabs are in groups of 5".
[17] Sudden spasm of the vocal cords.
[18] Medication used to cause short-term paralysis as part of general anaesthesia.
[19] Medical procedure in which a tube is placed into the windpipe through the mouth or nose.

26. At approximately 2.40pm, the surgery concluded. The "final count" section of the intraoperative record was left blank. The medical centre stated that the closing count was not completed or documented.

27. RN C told HDC that the "post procedure count … wasn't fully completed due to [her] being distracted by ongoing concern over the patient". Dr B stated: "[T]he ultimate responsibility lies with the surgeon and I have no hesitation in accepting that I should have checked that the [gauze] swab had been removed." Dr B also acknowledged that she did not follow up with the nurses to ensure that the gauze swab had been removed at the time.

28. At 5.15pm, Ms A was discharged home.

Discovery of retained gauze swab

29. Ms A said that on 30 January 2017, she began to feel "extremely unwell". She stated: "When I went to the toilet it felt like a part of me was falling out of my vagina and I was scared." Ms A telephoned Dr B. Dr B recalled Ms A explaining that she had noticed something sitting at her vaginal opening. Dr B said that at that stage, she realised that it was possible that a gauze swab could have been left inside the vagina.

30. Dr B asked Ms A to remove the gauze swab herself if possible, which Ms A did. Dr B arranged to meet at an accident and medical clinic, where she and an emergency physician examined Ms A. Over the next few days, Ms A received follow-up care from Dr B at regular intervals. Follow-up care continued during February, and Ms A was discharged back into the care of her doctor on 10 March 2017.

Incident reporting

31. The medical centre was unable to provide HDC with the "Adverse and Reportable Event Policy" that it had in place at the time of the events. The medical centre stated that when it updated its policies in July 2017, this resulted in the removal of some of its previous policies.

32. The medical centre told HDC that following the discovery of the retained gauze swab, the incident was reported to the practice manager and the medical director. Dr B stated that after she reviewed Ms A she informed the managing director and theatre manager of the incident. The medical centre reported that the theatre manager, RN C, completed an incident review, and a discussion was held with all staff involved. RN C told HDC: "[A]s soon as I heard of this incident, I led a review of the events leading up to this, reviewing and updating our policies and procedures." The medical centre told HDC that the review identified several complicating events that had distracted staff:

"
- The case was unusual due to an airway problem, causing the surgery to take much longer than usual, and some distraction to staff in theatre.
- There was a lack of clarity of the counting process with theatre staff and who should note on the countboard.

- The Scrub nurse was distracted and did not complete the post procedure swab count."

33. The medical centre told HDC that it has "no written record" of RN C's review.

Further information

Dr B

34. Dr B told HDC that she apologises to Ms A for inadvertently leaving the gauze swab in her vagina, and is deeply sorry for the understandable distress Ms A has experienced. Dr B said: "[T]his was completely out of character for me and is something that I very much regret." She emphasised that this was an isolated, genuine mistake, and that such a mistake had never occurred previously in her 20 years of practice as a specialist with high operating volumes.

35. Dr B told HDC that by way of an explanation, but not an excuse, the time period of early 2017 was a particularly stressful time for her outside of work. She said that she does not mean to shift any blame, but did not realise the extent of the stress she was under until later.

36. Dr B advised that the incident was discussed with the theatre team and a full debriefing occurred. She said that the theatre practice was reviewed and revised to ensure that a swab counting error does not occur again.

37. Dr B submitted that as the insertion of the gauze swab was not recorded by nursing staff after she announced it, even if the final swab count was initiated and verbally acknowledged in this case, the final count may not have identified the missing swab.

38. Dr B further submitted that there were systemic issues which contributed to the error occurring. These issues included a lack of clarity among theatre staff regarding the counting process, who should note the count on the whiteboard, and no initiation by staff of a final swab count.

39. Dr B commented that Ms A's procedure was difficult, with complications which distracted the relevant people from counting the swabs. Dr B stated that Ms A's respiratory condition was the focus at the end of the procedure, which both nurses attribute to why the post-procedure swab count was not initiated or completed fully.

40. Dr B advised HDC that these events have been a huge cause for reflection for her, and she has made changes to her practice. She stated that she has reviewed her communication practice with her colleagues and general practitioners.

The medical centre

41. The medical centre told HDC that it very much regrets what happened to Ms A, and apologises unreservedly. The medical centre said that it considered the lack of a formal count was a significant deviation from practice standards.

42. The medical centre stated that to minimise the risk of this happening in future, its "Operating Room Count Policy" was reviewed and updated with more detail, and all theatre staff and consultants were updated on the new policy and the importance of completing the count procedure. It also established an incident reporting template, and ensures that appropriate incidents are reported to the Health Quality & Safety Commission (HQSC).

43. The medical centre said that in 2019 it passed an audit of compliance with the Day Stay Surgery standards (New Zealand Standard 8164:2005 "Day-stay Surgery and Procedures"), which involved a review, update, and external check of its policies and procedures, and staff education during the process.

44. RN C also apologised unreservedly to Ms A for her error in not completing the count procedure.

Responses to provisional decision

Dr B

45. Dr B was given the opportunity to respond to the provisional decision. She advised that she had no comments to make, and accepted the proposed recommendations.

The medical centre

46. The medical centre was given the opportunity to respond to the provisional decision. It accepted the findings, proposed recommendations, and follow-up actions. It forwarded relevant sections of the provisional report to RN C and RN D, who had no comment to make other than to apologise to Ms A.

Ms A

47. Ms A was given an opportunity to comment on the "information gathered" section of the provisional decision, but did not provide a response.

Opinion: The medical centre — breach

48. In August 2016, HQSC released *Checklists, briefings and debriefings. An evidence summary*, which discusses the efficacy of communication and teamwork tools in the surgical setting. The report found that communication breakdown was the root cause in more than 50% of operative and postoperative adverse events. The report stated:

> "Performing safe surgery relies on the ability of surgical team members to combine professional knowledge and technical expertise with non-technical skills, including communication, teamwork, situational awareness, leadership and decision-making."

49. On 26 January 2017, Ms A underwent surgery led by Dr B. RN D was the circulating nurse, and RN C was the scrub nurse. Whilst both nurses were able to advise this Office of their

specific roles and responsibilities as circulating and scrub nurses, the medical centre reported to HDC that during Ms A's operation, there was a lack of clarity of the counting process with theatre staff and who should document on the count board. The medical centre stated that its Count Policy has since been reviewed and updated to include more detail.

50. Further, despite nursing staff and Dr B advising that they had knowledge of the process outlined by the Count Policy, they failed to comply with it as follows:

- An initial count was not completed. Only a partial initial count was performed by RN D and RN C. The Count Policy required that they verbally identify the items to be counted, including swabs, blades, and injection needles, and that this must be documented on the count board and in the intra-operative record.

- During the surgery, despite RN D hearing Dr B announce the insertion of a gauze swab, she neither communicated this to her colleague, RN C, or recorded it herself. The Count Policy required them to count and document all swabs, needles, and blades used during the procedure in the same way as the initial count, i.e. verbally identifying the items and documenting on the count board and the intra-operative record.

- A closing count was not completed by RN D and RN C at the end of the surgery. The Count Policy required that the closing count is to be performed in the same way as the initial count, verbally counting the items and checking this against the count board and the intra-operative record.

- Dr B did not confirm the status of the count before leaving the surgery.

51. The Count Policy stated that the count is a delegated medical duty, and "therefore the surgeon must verbally acknowledge the status at the end of the procedure". Dr B stated: "[T]he ultimate responsibility lies with the surgeon and I have no hesitation in accepting that I should have checked that the [gauze] swab had been removed." She also acknowledged that she did not follow up with the nurses to ensure that the gauze swab had been removed at the time.

52. A gauze swab was retained in Ms A's operation site.

53. The medical centre has told HDC that it considered "the lack of [a] formal count [to be] a significant deviation from practice standards".

54. A surgical count-in and count-out process is an important communication and team-work tool, which ensures the safety of the patient in the operating room. I am concerned that this process was carried out poorly by staff.

55. In particular, I have the following concerns:

- There were key points before, during, and after the surgery where communication was ineffective or non-existent. This is evidenced by the fact that only a partial initial

count occurred, that the nurses did not communicate with each other about the inserted gauze swab during the surgery, and that Dr B and nursing staff did not confirm the status of the count before leaving the surgery.

- Staff did not work together as an effective team to ensure that various steps in the count process occurred.
- The Count Policy lacked detail about the specific roles and responsibilities of staff, in particular, it did not specify who was responsible for recording on the intraoperative record and the count board. I note that the medical centre stated that staff lacked clarity about their roles and responsibilities in the counting process.
- As discussed above, that staff members were non-compliant with the Count Policy.

56. In this case, a pattern of individually unremarkable sub-optimalities (communication, policy clarity, and policy compliance) led to an oversight — the retention of the swab. All of these factors matter. While the case is by good fortune not one of significant harm — but is of significance to the patient, whose fear is noted above — it is an example of the need to be constantly vigilant to ensure communication is effective, policies are clear, and that they are complied with.

57. For the reasons outlined above, I find that the medical centre did not provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code).

58. I am also concerned that the medical centre did not document its review of the incident after the gauze swab was discovered. I note that the medical centre has strengthened its policies and processes around this, including the establishment of an incident reporting template as well as ensuring that it reports appropriate incidents to the HQSC.

Opinion: Dr B — breach

59. On 26 January 2017, Dr B performed surgery on Ms A. Dr B told HDC: "[T]he ultimate responsibility lies with the surgeon and I have no hesitation in accepting that I should have checked that the [gauze] swab had been removed." She acknowledged that she did not follow up with the nurses to ensure that the gauze swab had been removed at the time. The Count Policy also stated that the count is a delegated medical duty.

60. There were key points before, during, and after the surgery where staff failed to comply with internal policy, and as the senior clinician in the room, it was Dr B's responsibility to ensure that the counting procedures were adhered to. I note that:

- The Count Policy stated that the count was a "delegated medical duty, therefore the surgeon must verbally acknowledge the status at the end of the procedure".

- No closing count was performed by the nurses at the end of the surgery, and Dr B did not confirm the status of the count before leaving the surgery.

61. A gauze swab was retained in Ms A's operation site.

62. I acknowledge Dr B's personal circumstances at the time of the event, and her comment that this was an isolated and genuine mistake that had not occurred previously in her 20 years of practice as a specialist with high operating volumes. I also acknowledge that other staff did not follow the Count Policy, that there was a communication breakdown between Dr B and the nurses when she announced that she had placed a gauze swab, and that there were complications during the surgery.

63. Whilst there were wider systemic issues relating to communication and teamwork at play during Ms A's surgery, I note that Dr B accepts that ultimate responsibility lies with her as the surgeon, and that she should have checked that the gauze swab had been removed. I am critical that Dr B did not take adequate steps to prevent the retention of the gauze swab. As such, I find that Dr B failed to provide services to Ms A with reasonable care and skill, and breached Right 4(1) of the Code.

Recommendations

64. I recommend that Dr B:

a) Provide a written letter of apology to Ms A for the breach of the Code identified in this report, within three weeks of the date of this report.

b) Review the new Count Policy, present this case to her peers, and report to HDC her reflections on these events, within three months of the date of this report.

65. I recommend that the medical centre:

a) Provide a written letter of apology to Ms A for its breach of the Code, within three weeks of the date of this report.

b) Consider implementing team briefings and debriefings before and after surgery,[20] and report back to this Office on the outcome of its consideration within three weeks of the date of this report.

c) Report on the medical centre's use of the surgical safety checklist, within three months of the date of this report.

d) Perform a random audit of 15 patients from the past three months, to identify compliance with its Operating Room Count Policy. A documented report of the results

[20] As per HQSC's national roll-out for surgical teamwork and communication interventions: https://www.hqsc.govt.nz/our-programmes/safe-surgery-nz/projects/surgical-teamwork-and-communication/interventions/briefings-and-debriefings/

of the audit, and any changes made as a result of the audit, should be provided to this Office within three months of the date of this report.

Follow-up actions

66. A copy of this report with details identifying the parties removed will be sent to the Medical Council of New Zealand, and it will be advised of Dr B's name.

67. A copy of this report with details identifying the parties removed will be sent to the Health Quality & Safety Commission, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Nursing Council of New Zealand, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.