Adherence to count policy in surgery
17HDC02250, 27 September 2019

Medical centre ~ Gynaecologist ~ Surgery ~ Count policy ~ Retained swab ~ Communication ~Right 4(1)

A woman underwent a hysteroscopy, dilation and curettage with a polypectomy, insertion of a Mirena, and marsupialisation of a Bartholin's cyst. A consultant gynaecologist performed the surgery at a medical centre's onsite theatre.

The count policy stated that the count process is a delegated medical duty. During the surgery:

- An initial count was not completed. Only a partial initial count was performed by the circulating nurse and scrub nurse.
- During the surgery, despite the circulating nurse hearing the gynaecologist announce the insertion of a gauze swab, she neither communicated this to the scrub nurse, nor recorded it herself.
- A closing count was not completed by the nurses 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". The gynaecologist did not confirm the status of the count before leaving the surgery.

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

Findings

It was held 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 policy. For these reasons, the medical centre did not provide services to Ms A with reasonable care and skill, and breached Right 4(1).

The gynaecologist also breached Right 4(1). Whilst there were wider systemic issues relating to communication and teamwork at play, the gynaecologist accepted that ultimate responsibility lay with her as the surgeon, and that she should have checked that the gauze swab had been removed.

Recommendations

It was recommended that the medical centre provide an apology; report back to HDC on the outcome of its consideration of implementing team briefings and debriefing 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 count policy, and report the results and any changes made.

It was also recommended that the gynaecologist provide an apology; review the medical centre's new count policy; present this case to peers; and report reflections on these events.