CASE EXAMPLE 4

A patient with a latex allergy was put first on the list for fundoplication for a hiatus hernia. However the consultant surgeon did not know that patient had a latex allergy and changed the list order to put a diabetic patient first. This change was only verbally conveyed to the admissions ward and the theatre staff. Thus the patient for fundoplication patient was not ready to be sent up when called for. Eventually the consultant anaesthetist noticed the problem, discussed with consultant surgeon and they restored the patient to be first on the list but this meant a late start and everybody was rushing.

Latex allergy is supposed to be highlighted on the op list but the software is so bad that nearly everybody missed it (the anaesthetist took the list to 20 people who regularly work in theatres and only one person noticed it). Thus, the scrub staff did not know of the latex allergy and the scrub nurse wore latex gloves and started prepping. It is only when the patient came into the theatre that everybody realised the error. However, being a specialised procedure with special equipment, there was only one liver retractor which now could not be used and the surgeon had to use a grasper. The patient was obese, turned out to have a large left lobe of liver and the grasper cut through the liver and caused a laceration and bleeding. The operation was made difficult but proceeded uneventfully without any immediate complications.

However, the patient then developed a failure of the procedure a year later and recurrence of his hiatus hernia for which he will need redo surgery.