

Flash Sterilization: Patient Burned, Jury Blames The Nurses, Not The Surgeon.

According to the record from the Circuit Court, Monroe County, Indiana, the hospital only had one O'Connor-O'Sullivan retractor and it had been used earlier in the day on a procedure with a different patient.

The retractor was needed for the abdominal hysterectomy the obstetrician was starting, so the nursing staff were asked to clean it and then flash sterilize it in the autoclave in the operating room.

It was handed to the surgeon still hot from the autoclave. The surgeon laid it on the abdomen as the area was being prepped. The patient awoke with a second-degree burn in addition to her surgical scar.

The surgeon and her medical group were dismissed from the case on summary judgment.

Cooling of Surgical Instruments

Perioperative Nursing Responsibility

When the case went to trial against the hospital the jury heard expert testimony to the effect that responsibility lies with the perioperative nursing staff for ensuring that an instrument newly flash-sterilized is appropriately cooled before being handed to the surgeon.

The jury apparently believed the expert's testimony and gave the patient a verdict of \$5,000.

The patient had additional expert testimony that repair of the scar will cost \$8,000 to \$10,000, not to mention the pain and suffering from the original injury and additional down-time for the revision surgery.

The patient's lawyers petitioned the court to deem the jury's verdict inadequate and to increase the damages to be awarded to the patient accordingly, but the court refused. **Allen v. Bloomington Hosp., 2007 WL 5145137 (Cir. Ct. Monroe Co., Indiana, September 18, 2007).**