

Perioperative Nursing: Nurse Must Check That Equipment Has Cooled After Flash Sterilization.

The patient sued the hospital and the orthopedic surgeon's practice group after she sustained third degree burns on her upper arm from a wrist traction tower that was used in her wrist surgery.

Some of the Parts Had Not Cooled Patient Was Burned

A perioperative nurse was responsible for gathering all the instruments, supplies and equipment ordered for the case, including a wrist traction tower.

The traction tower was not sterilized after being used the day before. She put all the metal component parts in a metal pan and flash sterilized them for four minutes at 270° F. Then the nurse took the pan out of the autoclave with oven mitts, put the pan on a table in the operating room and took the lid off to allow it to cool, about an hour before the case was scheduled to start.

The orthopedic surgeon and the scrub nurse, a hospital employee, assembled the wrist traction tower on the sterile surgical field after the patient was under anesthesia, put the patient's arm in it, draped the arm and wrist and went ahead with the case.

None of the parts they touched seemed too hot. However, according to the Court of Civil Appeals of Alabama, the fact that the patient sustained burn injuries was evidence that all the component parts of the entire apparatus were not given time to cool and were not checked for residual heat before being used.

The Court was quick to throw the circulating nurse who flash-sterilized the equipment one hour before the procedure into the mix to share the blame, without explaining how she could have checked the temperature of the sterile equipment, as she would not have been able to touch it after it had been sterilized.

Padding Not Documented

The surgeon's and the nurses' surgical reports included no documentation that the traction tower's manufacturer's recommendation was followed for cloth or gauze padding to be inserted between the skin and all metal parts that might contain residual heat from recent sterilization. **Ford v. Stringfellow Mem. Hosp.**, ___ So. 3d ___, 2009 WL 3415304 (Ala. App., October 23, 2009).

The hospital's RN director of surgical services testified that it is important for patient safety that surgical devices such as the wrist traction tower be properly cooled before being used in surgery.

The standard of care in the national medical community is that the individual person who flash sterilizes equipment to be used with a patient in surgery after flash sterilization is responsible for allowing enough time for it to cool it before it is used.

It is necessary that all component parts of the equipment be allowed to cool and be checked to make sure they are cool enough that the patient will not be injured.

The scrub nurse who helped the surgeon assemble the device on the sterile field testified that none of the parts she actually touched seemed to be too hot.

However, the fact the patient was burned is evidence that some of the parts were too hot and that the nurse's and the surgeon's actions were not up to the standard of care.

COURT OF CIVIL APPEALS OF
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