

Endoscope – An unusual problem

An orthopaedic surgeon was performing a knee arthroscopy. The case required the use of an arthroscopic 'shaver' – the shaver was inadvertently plugged into the operating console of a manufacturer different to the shaver itself. The shaver overheated and an underlying plastic water collection drape was melted by the heat. The problem was then recognised and the operation completed. After the procedure the drapes were removed and it was noted the patient had sustained a small burn (one by two centimetres) to the proximal thigh in the inguinal region.

Following this incident the theatre technician stated that when the lead was inserted into the console it was noted that the pins of the shaver did not easily fit. Despite this the technician went ahead and pushed the fitting 'home' regardless. It is important that the theatre 'equipment stacks' contain only one type of equipment and brand to minimise the chances of such a mismatch occurring.

In this particular case it was an agency technician that was involved. It is important that a system is in place to evaluate the experience of agency staff before either accepting their service for a shift or allocating them to a particular clinical case.

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