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CORESS Feedback

CONFIDENTIAL REPORTING SYSTEM IN SURGERY

This edition of CORESS Feedback features two cases which emphasise a recurring theme centred around the need for full documentation and patient details to be available in order for correct surgery to be undertaken safely. We are grateful to the clinicians who have provided the material for these reports. The on-line reporting form is on our website ***www.coress.org.uk*** *which also includes all previous Feedback Reports.*

MISSING NOTES AND MISTAKEN IDENTITY

(Ref: 59)

A patient, whom I knew well, came to theatre for 'closure of a colostomy'. The medical notes could not be found when I checked the heavily sedated patient in the anaesthetic room (they turned up later having been sent to the X-ray department in another patient's file). It was a busy list, which was only just possible to accommodate in the time available if everything ran smoothly. I elected to proceed with the operation rather than to send the patient back to the ward. It was a mistake. I closed what I had remembered as a loop-colostomy, by simple closure of the defect. Sometime later, the ward sister rang, when the notes had been recovered, having realised that I had, in fact, closed an end-colostomy. The list had been altered and another patient substituted; a man of similar age, who was merely due for refashioning of his end-colostomy. The patient, by this time, was fully recovered. Following a highly embarrassing interview with the patient and his relatives, he was re-anaesthetised the following day and the correct procedure was completed uneventfully. A modest financial settlement resulted.

Reporter's Comments:

This was not the happiest time of my surgical career. I succumbed to that oldest of mistakes; trying to cut corners to squeeze in as much work through an overloaded system, as possible. A change of anaesthetist and busy ward staff, plus a slip in the theatre protocol for altering theatre lists, did not help. The theatre services team have since agreed with my suggestion that under no circumstances will patients for elective surgery be accepted into the theatre suite without full documentation accompanying them, and alterations in theatre lists must be properly documented within the theatres. Regardless of any pressure to the contrary, never feel that you have to proceed with an operation without being entirely satisfied that all necessary documentation and results of relevant investigations are available. I thought that it would never happen to me: but it did. Do not rely on memory alone.

CORESS Comments:

This is a case with an important message. We cannot help but agree with the Reporter's analysis of the underlying problem and the **CORESS** Advisory Committee is grateful for his frank account and recommendations. If it is any small consolation, several other cases of a similar nature, involving errors surrounding closure of colostomies, had been encountered by members of the Advisory Committee.

As the Reporter identifies, this is a systems failure, where two of the major built-in safeguards in standard protocols were removed, leaving it all down to that most capricious of faculties, our memory. No operation should proceed without review of the appropriate documentation and, at minimum, the presence of a signed consent form. Most hospitals will have in place several checks in the pathway from the ward to the surgeon's knife. Colleagues are advised to be familiar with them and ensure that they are followed.

POOLED LISTS

(Ref: 60)

Patients awaiting colonoscopy in our Trust have recently been pooled, to reduce waiting times. I recently encountered a patient, well-known to another Consultant, who had been placed on my list without my knowledge and who appeared on the day unit on morning of the proposed procedure. Unfortunately, his notes were unavailable. The patient was concerned that I might not be aware of the fact that he was taking warfarin for a prosthetic heart valve. He was quite right. Following careful discussion with the patient, a diagnostic procedure was undertaken. At a second appointment, after implementation of the Trust's care pathway for anticoagulated patients, a large polyp was removed from his sigmoid colon.

Reporter's Comments:

Pooled lists are only safe if the Consultant concerned has appropriate knowledge of the patient and full access to clinical records. Ideally, these examinations should be performed under the care of the Consultant who is responsible for the patient.

CORESS Comments:

Pooled lists are now a common feature in surgical and endoscopic practise. Whilst a clinician who

places a patient onto a pooled list should ensure that any background clinical conditions or potential complications are flagged up at the time of listing, it is the responsibility of the operating clinician to ensure that it is safe to undertake the proposed procedure. Clinicians must embrace the mindset of checking each patient prior to undertaking any invasive procedure.

DISTRACTING FRACTURE

(Ref: 61)

A seven year old girl fell off a swing and attended our emergency department, with an injured right arm, on a Friday afternoon. She was assessed, in the company of her mother, and noted to have an obvious swelling of the right forearm. She was immediately treated with opiate analgesia and sent for an x-ray which demonstrated a greenstick fracture of the right radius, with minimal angulation. A plaster cast was applied and she was discharged, with planned follow-up in the fracture clinic after the weekend. The following day, she returned with pain in the left forearm. On examination, tenderness was noted over the left distal radius. Another x-ray was performed, confirming a 'buckle' fracture of the left distal radius. This too, was treated with a plaster cast.

Reporter's Comments:
There was failure to appreciate possibility of bilateral injury. The more serious injury distracted the attention of the patient, her mother and medical staff. Opiate analgesia was provided before preliminary examination. Bilateral injuries occur commonly. Preliminary examination should precede opiate analgesia. Both limbs should be x-rayed if the history is suggestive of bilateral injury.

CORESS Comments:
The Advisory Committee agreed that the more painful limb had distracted attention from the left radial fracture here. However, secondary injuries are common in polytrauma. The mainstay of diagnosis remains examination of the patient. Use of diagnostic tests does not excuse the clinician from full and appropriate examination. Early treatment with opiate analgesia was felt to be appropriate in this case.

ANASTOMOTIC LEAK

(Ref: 62)

An 18 year old female with obstructing Crohn's disease had undergone medical treatment which had 'failed', militating early bowel resection. She had little support and was the sole carer of her widowed father who had metastatic malignancy. The patient wished to continue to care for her father and was very keen to avoid a stoma. Having been ill herself, for some time, she had lost weight and was malnourished. I performed an extended right hemicolectomy and primary anastomosis. The anastomosis leaked on the 6th postoperative day and a temporary end ileostomy was constructed, with subsequent reconnection after her father's demise.

Reporter's Comments:
I failed to take account of the patient's malnutrition despite her young age, perhaps choosing an inappropriate course of management based on sympathy for the patient who was in a very difficult emotional situation. Maintenance of a degree of professional detachment in the management of clinical problems should be tempered with appropriate empathy for patients in such circumstances. The map is not always the country.

CORESS Comments:
Empathy for a patient shouldn't be allowed to cloud clinical judgement, but most clinicians are exposed to similar circumstances at some time or another. The **CORESS** Advisory Committee felt that the surgeon made a reasonable decision in this case, although the patient suffered from complications of surgery. Adequate informed consent, with full explanation of treatment options and risks, may guide the patient to make an appropriate treatment choice and encourages sharing of the burden of risk.

FINALLY...

Shock-coated catheter?
MRHA has received reports of users inserting chlorhexidine-coated central venous catheters into patients with a known hypersensitivity to this agent, causing anaphylactic shock.

Comment:
Ensure that an appropriate device for patients with known, or suspected, hypersensitivity is selected. Check labels and warnings for known contraindications.

MORE ON CATHETERS:
Trial by error…
Incidents of angioplasty catheter tip breakage, some with balloon separation, have been reported after use of excessive force on withdrawal.

Comment:
If resistance is encountered on removal of either the guide wire from the catheter or the catheter from the introducer sheath, consider removing them as a single unit to prevent damage to the device or vessel.

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