Summer 2021

Addressing patient safety: the Confidential Reporting System for Surgery (CORESS)

By **Professor Frank Smith**

Issue 21 Summer 2021

Professor Frank Smith of CORESS explains how the charity gives surgeons a new opportunity to share and learn from their experiences.

Introduction from the MDU

It is a fact of medical life that not everything goes to plan, and sharing learning with colleagues is an important part of a clinician's response. The independent charity organisation CORESS promotes safety in surgical practice in the NHS and the private sector by encouraging sharing of information and learning between surgeons to protect patients.

Sometimes, however, one clinical incident can result in a cascade of different medico-legal issues which can be hard for doctors to manage, and that multiple jeopardy can, at worst, limit a doctor's ability to practise their profession.

As an organisation run by doctors for doctors, the MDU knows this, and we work to keep our members safe - protected as far as possible from the vicissitudes of practice.

Whenever our members contact us, they always speak to a fellow clinician. MDU advisers are doctors specialised in supporting our members through what can be traumatic periods of their professional life, and part of our input is often to

encourage members to reflect on events and share any learning with colleagues.

This sharing of patient safety information is common to how both organisations approach clinical incidents, with the MDU ensuring that doctors are supported to learn from incidents if appropriate, and CORESS ensuring that learning is disseminated to as wide an audience as possible.

The MDU is happy to support CORESS in its core mission.

Jerard Ross, MDU medico-legal adviser

A CORESS report - retained gallbladder at laparoscopic cholecystectomy

The following is a real case reported to CORESS, published with permission. Details have been anonymised.

"A 38-year old patient underwent urgent laparoscopic cholecystectomy for cholecystitis. This was the third similar case on a busy theatre list, and the procedure proceeded uneventfully. The gallbladder was placed in a bag and stowed above the liver, prior to a final check of the abdomen before removing the gallbladder.

"At this point I noticed some bleeding from the gallbladder fossa, which was difficult to control and necessitated application of pressure with a swab, inserted through one of the laparoscopic ports. The swab became soaked with blood and expanded, and it took some effort to extract it through the port.

"As the swab was delivered, the consultant (who had taken over and helped to remove the swab) and I were both relieved to have extracted it. We immediately took the ports out, forgetting that we had not yet extracted the gallbladder, which was still in the bag above the liver.

"The situation was compounded by the scrub nurse failing to realise that she hadn't handed the gallbladder out of the operative field, and that the

laparoscopic bag had not been counted out of the abdomen. There was also a

failure to check if the specimen was actually in the pot, despite labels being dutifully checked for the WHO sign-out check.

"The patient was woken up and taken to recovery, and the mistake was only realised when the pathology department rang to alert the theatre that an empty pot had been received. The patient was immediately informed, and went back to theatre from the recovery area, requiring a second anaesthetic to extract the gallbladder in the bag. The team had a full debrief at the end of the day and later participated in a root cause analysis for the events that had occurred."

CORESS & reporters' comments

It is easy to become distracted at a critical point in an operation and to focus only on the task in hand, rather than on the bigger picture, and this case demonstrated system errors involving the whole team.

There were numerous individual points when the surgical error could have been recognised; at the stage of retrieving and handing out the specimen, including the gallbladder bag in the scrub count, checking the specimen into the pot, or sending an empty specimen pot to pathology. This is a classic example of Reason's Swiss Cheese Model, where multiple holes line up to allow a hazard to be converted to an accident.

These stages have been scrutinised and theatre staff have had training in new protocol to try and prevent a similar event from happening again. The patient was discharged that night, and, despite having two anaesthetics, made a good recovery.

Learning from mistakes

As a clinician, have you ever been involved in, or been aware of, an adverse incident

or near-miss in your practice, or that of a colleague?

Most experienced doctors have encountered such events. If you had known specifically about the risks and circumstances leading up to that incident, before it happened, would that have reduced the risks of the event taking place?

The purpose of CORESS is, exclusively, to share lessons learned from unexpected or adverse incidents in surgical practice. In this, CORESS shares the same objectives as the MDU, which as a defence organisation supports doctors where similar mistakes occur.

At a time when it can feel as though the 'blame industry' is in overdrive, that defensive practice is ever more common and bureaucracy is overwhelming us, do surgeons really need another incident reporting system?

This was the very reasonable question put to the Association of Surgeons of Great Britain and Ireland (ASGBI) when CORESS was proposed in 2006. The answer, of course, was that if the proposal was simply another layer in the clinical governance framework, then it was unlikely to succeed. So what is different about this reporting system?

CORESS is similar to a system set up for aviation in 1982 following several high-profile accidents. When CORESS was devised, the organisation was assisted by the chief executive and his team at the aviation system (CHIRP), and although there are differences between systems suitable for aviation and surgery, the principles under which the system should operate remain the same.

The purpose of CORESS is, exclusively, to share lessons learned from unexpected or adverse incidents in surgical practice.

Reporting principles

Firstly, there must be complete confidentiality between the reporter and the

Firstly, there must be complete confidentiality between the reporter and the system. Confidence in the integrity of the system is essential in this respect. Next,

the educational value of feedback both to the reporter and to the professional body concerned must be excellent. For there to be confidence in the credibility of feedback, any panel of 'experts' must include people of acknowledged distinction who actively practice their profession. Lastly, confidence in the system by those interested but not directly involved is essential.

These systems are complementary to existing statutory, professional and organisational measures for the protection of the public; they do not replace them. The necessary support of regulatory bodies and society in general is dependent on this being made very clear. These principles are embodied in the operating framework of CORESS, which became an independent charity, introduced by Sir Bruce Keogh at the House of Lords in 2010.

How CORESS works

CORESS is a service provided by surgeons for surgeons and is concerned with any safety-related issue from which lessons can be learned. Any surgeon, surgical trainee, or member of the wider surgical team, irrespective of specialty, can submit reports in confidence to CORESS.

Reports can be made online via the website or by mail, using a downloadable form. Reports may concern any safety-related incident involving the reporter, other people, a hospital or other organisations the reporter deals with. Incidents may be diagnostic or operative errors, technical or maintenance failures, regulatory or procedural aspects or unsafe practices and/or protocols.

Useful lessons can often be learned from incidents that do not result in adverse consequences and may only be known to the reporter. However, there is no educational value in incidents where no lesson can be learned. Incidents with no safety content, or issues involving conflicts of personalities and problems involving industrial relations or terms and conditions of employment, are not generally useful.

Confidentiality

Confidentiality is fundamental to the concept of the CORESS service. When a report is received, it is transferred to a stand-alone computer with no wired or wireless connections to any network. Identifying data are available only to the programme director. All identifiable data are removed before a report is reviewed by an advisory committee of experts in the appropriate specialty, all of whom have signed a confidentiality agreement.

If useful lessons can be learned, an unidentifiable version is incorporated in a feedback document. This will be published in the Annals of the Royal College of Surgeons of England, Surgeons' News of the Royal College of Surgeons of Edinburgh and the Journal of ASGBI, and also distributed to other interested bodies. All reports are anonymised and identifying data is securely deleted from the CORESS system before any feedback publication. Contributors are provided with a 'Certificate of Contribution to Surgical Safety', which may be useful evidence for training or appraisal portfolios. Previous reports can be found on the CORESS website.

How does CORESS contribute to safety?

Unlike mandatory reporting systems, CORESS does not systematically analyse and feedback information to NHS organisations. Rather, CORESS aims to complement this activity by providing individual feedback to surgeons and to the surgical community in general.

"There but for the grace of God go I" is a powerful educational tool that surgeons have always valued, but perhaps have felt less able to use in recent years. CORESS gives us a new opportunity to share our experiences.

You can visit CORESS at the organisation's website, coress.org.uk

---

Professor Frank Smith

Frank Smith is professor of vascular surgery and surgical education at the University of Bristol, UK. He has interests in education and training, and safety in surgery. He trained in vascular surgery in the UK, undertaking travelling fellowships to Boston, Denver, Los Angeles and Seattle. He is programme director of CORESS. He represented CORESS on the NHS England Never Events Task Force and chaired the Key Surgical Factors writing group for the National Safety Standards for Interventional Procedures (NatSSIPS). He is an elected member of Council of the Royal College of Surgeons of England.

See more by