coress feedback

CORESS Feedback: Cases from the Confidential Reporting System for Surgery

CORESS is an independent charity, supported by the MDU and the WPA Benevolent Foundation

The series of cases in this edition of Surgical Life illustrates the perennial theme of poor communication contributing to many adverse incidents or near misses. These cases have occurred in a number of specialties, emphasising the need for good communication as a central theme across all surgical practice.

We are grateful to those who have provided the material for these reports. The online reporting form is on the website (www.coress.org.uk), which also includes all previous Feedback reports. Published cases will be acknowledged by a Certificate of Contribution, which may be included in the contributor's record of continuing professional development, or may form part of appraisal or annual review of competence progression (ARCP) portfolio documentation. Trainee contributions are particularly welcome.

CORESS would also welcome any reports which may have arisen as consequences of the COVID pandemic.

Professor Frank CT Smith
On behalf of the CORESS Advisory Board

Unrecognised limb ischemia following trauma

(Case ref: 281)

A 37-year old man was admitted to the Emergency Department having been involved in a road traffic collision on his motorcycle. He had femoral shaft and tibial fractures in his right leg. He was taken over by the trauma team who assessed his limb and felt that perfusion was adequate and the limb viable.

The patient was placed on the emergency operating list for repair of his femoral fracture and placement of an external fixator, but the procedure was delayed due to a number of other trauma cases. Late in the day, some 12 hours after admission, it was recognised that the patient had a pale, cold leg with no ankle Doppler signals. A referral was made to the hub vascular unit and after further delay in securing transport, the patient was transferred for vascular assessment.

CT angiography at the receiving hospital confirmed occlusion of the femoral artery and complete occlusion of the distal arterial tree. The femoral artery was explored surgically, repaired with an interposition vein graft, and extensive distal thrombectomy was undertaken with fasciotomies, before the femoral fracture was fixed.

The appearance of the leg however failed to improve, and repeat CT angiography at 24 hours showed very limited perfusion of the leg from the level of the knee, with no run-off into the foot due to persistent thrombus. Four days after his accident, an above-knee amputation was undertaken.

Reporter's comments:

Despite initial satisfactory appearances, the extent of ischaemia in this patient's leg was not recognised, in association with an injury in which there was high risk of arterial damage. Any concerns at the time of admission should have led to early formal assessment of the limb circulation including documentation of ankle Doppler signals and pressures, and CT angiography if the patient was stable. The situation was compounded by delays in access to the emergency theatre and in transfer to the vascular unit, by which time the leg was beyond the limits of salvageability.

CORESS comments:

Many such patients will be sent directly to a Major Trauma Unit as part of a Trauma Network. Where specialist input is required, early transfer to a Major Trauma Centre which is able to provide pan-specialty services such as the vascular input required here, is indicated.

In this case there should have been high index of suspicion for concomitant vascular injury in the presence of extensive lower limb bone fractures. Regular monitoring of leg pulses and perfusion, with appropriate imaging, as suggested by the reporter, should have been undertaken. Early referral for vascular assessment and intervention might have improved the eventual outcome.

Differences of opinion in management for tongue laceration (Case ref: 282)

A 7-year old child with learning difficulties was brought to a tertiary unit by his mother and grandmother, having bitten his tongue with a resultant full thickness laceration of approximately 45% of the left lateral aspect of the tongue. Perfusion was judged to be adequate.

He was reviewed by the on-call Dental Core Trainee who had only recently started working in the hospital. The wound was not actively bleeding, but the region was sore and unlikely to heal favourably and was at risk of infection. The Core Trainee discussed the case by telephone with the registrar on-call, who was covering several local hospitals. The extent of the trauma was made clear and the Core Trainee indicated that she thought this would benefit from primary closure, the child having been starved since the incident.

However the advice from the registrar, who did not see the patient, was to treat the lesion conservatively, to explain the likelihood of a scar or polyp formation and to review the patient again in a few days. This was documented and the patient handed over to the day team with arrangements for a follow-up appointment.

On subsequent review one week later, the wound was not healing adequately. The parent reported that the child was in pain, was unwell and had reduced appetite. The child was then seen by a Consultant in the Trauma Clinic and was listed for theatre for debridement, revision and closure.

Reporter's comments:

The DCT could have requested that the patient be seen a senior member of the team if she was unhappy with the management advice. Failure to do this may have been compounded by lack of familiarity with the hospital, and potentially by lack of accountability of the registrar who was covering numerous units. In current surgical practice where specialties work in a team setting, no junior staff should be afraid to call the on-call Consultant if they have a query, although concerns about bypassing the normal “chain of command” may have influenced the trainee’s actions in this situation.

CORESS comments:

On this occasion there was division of opinion amongst expert oral maxillofacial commentators on this report. One felt that provided that the tongue flap was not devitalised, it was likely to heal without intervention and that in this case it was reasonable initially to manage the wound conservatively. The other felt strongly that the registrar should have seen the patient, and that a primary repair was probably indicated. In either case it was important that someone with experience of such injuries examined the patient so as to provide an informed opinion. Small lacerations usually heal spontaneously, whilst it may be necessary to trim a vertical laceration, or indeed, to occasionally remove a piece of tongue to facilitate healing.

There were broader hierarchical issues with respect to communication here. A Board member commented that a photograph of the lesion could have been sent to the registrar to inform decisions about clinical management if he was not able to examine the patient personally.

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Lack of communication in patient discharge (Case ref: 283)

A 63 year-old man with diabetes, chronic Stage 3 kidney disease, and ischaemic heart disease was admitted with a necrotic 5th toe, cellulitis and hyperkalemia. Surgery to amputate the toe and debride localised tissue necrosis was undertaken under regional anaesthesia within 24 hours.

The wound was reviewed the next day by the Consultant, who took the dressing down on the post-operative ward round. The patient was discharged with a five-day course of antibiotics and an appointment for review in the diabetic foot clinic 2 weeks later. However, there was no communication with the patient about the frequency of required dressing changes. No nurses were present on the ward round and no information was given to the nurses about dressing changes on a verbal handover, nor was there a formal handover from the inpatient nursing team to the community nurses.

The patient was readmitted at 8 days postoperatively with spreading sepsis and subsequently required amputation of 3 other toes on the same foot.

Reporter's comments:

This case illustrates the poor outcomes associated with failed communication at different stages in the patient journey. Whilst the patient was seen promptly postoperatively, there was failure of the surgical team to communicate crucial management issues to the nursing team responsible for the patient's discharge. This could have been queried at this stage, but was not, and no instructions were issued to the community nurses who form a vital part of the postoperative care team. It is the responsibility of the surgical team to ensure that adequate postoperative instructions are directed to those responsible for the patients discharge and community care. Regular team meetings of all involved in surgical patient's care, surgeons, nurses, physiotherapists and occupational therapists, fosters team spirits and may enhance communication and patient care.

CORESS comments:

A collaborative care pathway with written protocols for patient discharges, and early community nursing involvement, might have reduced the risks of the adverse outcome which arose as a result of poor communication.

Consequences of Service Disruption during the COVID-19 Pandemic (Case ref: 284)

A 64 year-old man presented with a mixed arterio-venous lower leg ulcer. Duplex ultrasound and CT angiography confirmed mild deep venous incompetence and a 10cm superficial femoral artery occlusion. He underwent femoral artery angioplasty and placement of an uncovered stent, improving his Ankle Brachial Pressure Indices, allowing him to be placed in 4-layer graduated compression bandaging to treat the venous component of his ulcer.

Stent surveillance by duplex ultrasound would usually have been undertaken at routine 3 monthly intervals for the first year after stent placement, but this was postponed because of changes in routine practice due to the COVID-19 pandemic.

The patient was seen in the vascular Hot Clinic as an emergency referral 4 months after intervention, at which time his leg ulcers had deteriorated to the extent that tendons were exposed and there was severe necrosis of skin on the dorsum of his foot. Ultrasound confirmed that the stent had occluded, whilst he had remained in compression bandaging.

The foot was deemed non-salvageable and the patient underwent below-knee amputation. He was making a good recovery from amputation, with early mobilisation, when he developed a hospital-acquired COVID-19 infection. His respiratory function deteriorated rapidly requiring ITU admission. He developed further thrombotic sequelae of COVID-19 and SIRS, with digital necrosis of fingers, requiring a prolonged stay on ITU.

CORESS comments:

The impact that COVID-19 has had on routine clinical services is well-recognised. This case is a salutary reminder that expected clinical surveillance as part of follow-up protocols after emergency interventions should be adhered to wherever possible. Telephone follow-up clinics will not be suitable for some patients. Development of improved communication links between community services and the surgical team might have helped identify continued deterioration of this patient's presenting condition.

Systems and Communications Errors Leading to Orthopaedic Never Event (Case ref: 285)

An experienced surgeon put the wrong sized implant into a male patient during a hip replacement.

The surgical team work together regularly and use the WHO Surgical Safety Checklist. They are strong supporters of both pre and post-op briefings. They work in a very busy environment where rapid surgical technique and turnaround is the norm. Expectations regarding continuous efficiency gains are a part of daily life.

During the pre-operative briefing, implant sizes were discussed. The hip implant comprises four elements. The socket and a separate liner are packed together in one box, the head in a second, and the stem in a third. Each element can be of a different size to suit the patient, and each has specific measurement.

The head though has two measurements – the head diameter, which must fit snugly with the socket that is fitted, and the length, which is an independent variable. One combination of these implant sizes was considered most likely to suit the patient, but another was brought into theatre as a contingency.

The surgeon made the final size decisions regarding size during a visual examination after commencement of surgery. He was passed the correct sized socket, which was then positioned. When ready for the head of the implant, the surgeon asked for a "+5" a reference to the length not the diameter of the head. The diameter is not normally specified at that point as this it is automatically defined by the size of the cup, which had already been implanted. It was seen as a given by all involved.

The runner passed the head to the scrub practitioner who confirmed the length as "+5" but not the diameter. The surgeon assumed that he was being passed a head that matched the socket.

The socket and the head of the implants are packaged separately. The head length is identifiable on the box under a cellophane wrapper. The head diameter however is amongst other text and less prominent. Some manufacturers colour code the boxes, this manufacturer does not.

The operation was duly completed; the sticker from the implants attached to the operation notes and entered into the computerised national register.

The error came to light approximately 12 months later when the patient was reviewed in outpatients. The patient reported on-going discomfort and occasional looseness of the joint when coming downstairs. Whilst investigating possible causes, the surgeon reviewed the operation notes. He noticed that the implant stickers showed that the diameter of the socket and the head were incompatible.

The surgeon disclosed the error to the patient and apologised. The patient consented for a further operation to correct the error. The incident was reported and duly investigated. The patient made a claim for compensation and the Trust admitted liability.

When asked what he thought went wrong, the surgeon replied:

"The runner thought the scrub nurse would check the size, the scrub nurse thought the runner has already checked it, and I thought the scrub nurse had checked it. In practice therefore no one had checked it. We all believed that what we were being passed was the right thing."

CORESS comments:

Despite the surgical team working in a safety conscious environment, this incident arose out of a mixture of systems errors, which included variability in packaging of prostheses, communication problems, and failure to employ routine safety protocols for checking the prosthesis prior to implantation.

This case is taken from Report of NHS England Never Events Task Force to which CORESS contributed: Standardise Educate, Harmonise. Commissioning the Conditions for Safer Surgery. Feb 2014 http://www.england.nhs.uk/wp-content/uploads/2014/02/sur-nev-ev-tf-rep.pdf.

The findings of the former report led to the development of the National Safety Standards for Invasive Procedures (NatSSIPs) which all surgical teams should incorporate into practice.

http://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/09/natssips-safety-standards.pdf

A subsequent comprehensive report on this topic has been published by the Healthcare Safety Investigation Branch (HSIB), entitled: Investigation into the implantation of wrong prostheses during joint replacement surgery Jun 2018

https://www.hsib.org.uk/investigations-cases/implantation-wrong-prostheses-during-joint-replacement-surgery/

Too slick by half (Case ref: 286)

A trainee surgeon, aiming to expedite a morning day-case list by efficient management of paperwork, pre-completed the consent forms for the 5 patients due to undergo hernia repair. This included signing and dating the forms, prior to seeing the patients. He was then called away to deal with a ward emergency, and a colleague took over, seeing the patients and marking the appropriate site of surgery. The colleague, seeing that the consent forms were already signed, and assuming that the patients had already been seen, merely asked the patients to sign them and marked the side indicated on the consent form.

The first patient arrived in theatre and in the pre-anaesthetic check, the anaesthetic nurse, during questioning, noted that the patient's symptoms were on the opposite side to that marked and indicated on the consent form. It transpired that the affected side had been incorrectly listed on the theatre list, to which the surgical trainee had referred, prior to completing the consent form.

Reporter's comments:

Despite the trainee's best intentions, this was an inappropriate short cut taken to try to improve efficiency at the expense of patient safety. It is the responsibility of the operating surgeon to make sure that he or she is undertaking the correct procedure on the appropriate side and site. Examination of the lesion and then marking the site/side is a vital undertaking prior to surgery. The thorough attention of the anaesthetic nurse in this case prevented the occurrence of a "Never Event".

CORESS comments:

This was a classic example of the "swiss cheese effect", where several errors lined up to contribute to a "near miss". The operating surgeon should check all patients before they are anaesthetised. A formal team brief and correctly performed WHO checks should have identified this problem. The psychologist on the Advisory Board noted that there is a tendency to re-affirm what has been done before, rather than to "check and challenge". The paperwork should never be completed and signed off before the clinical task is undertaken.

Journal of the Association of Surgeons of Great Britain & Ireland

We would greatly appreciate your feedback to further enrich the content and format of the JASGBI!

Please complete the survery (link below) to tell us what you think

https://www.surveymonkey.co.uk/r/X26JQC7

Journal of the Association of Surgeons of Great Britain & Ireland

Contributor Guidance

(As at Summer 2017)

The Association welcomes and encourages contributions from Fellows and asks that potential contributors take the following guidelines into consideration.

Aims

The Journal of the Association of Surgeons of Great Britain and Ireland (JASGBI) is a regular publication that has evolved from the previously named Newsletter. It aims to publish material of topical or general interest to members of the Association, which will promote and advance the reputation and functions of the Association to a wider professional audience.

JASGBI is not a peer reviewed, academic publication, and is not intended as a vehicle for conventional academic papers. We nevertheless welcome a wide range of subject matter which may include:

- Articles of national and strategic relevance in relation to surgical training, teaching, career development, and issues in national politics, as they bear upon surgical and professional practice.
- Articles of topical debate.
- News from the Regions, and from affiliated Specialty Associations and Societies.
- Articles on international surgical practice, as observed by members of the Association on their travels, attachments and secondments.
- Historical articles of interest and relevance to surgeons.
- Personal experiences, parallel careers, hobbies, activities and achievements which are out of the ordinary, or which would fit our popular 'Secret Lives' series.

This list is not exclusive. JASGBI is keen to encourage and help develop standards in professional writing and to act as a vehicle for new and original material.

Publication Standards

Although JASGBI is not a conventional, peer reviewed academic publication, we subscribe wholeheartedly to the highest standards in respect of Publication Ethics and the elimination of the various forms of publication malpractice, as set out by the Committee on Publication Ethics (COPE) and the World Association of Medical Editors (WAME). Material submitted to JASGBI should thus be original to the author(s). The editors reserve the right to submit any manuscript to peer review and to seek any amendments which are deemed to improve the presentation or content of the article to meet the standards and style of JASGBI.

Article length

Each page of JASGBI can accommodate around 750 words with a small picture. While we are flexible as to content, articles should usually be of 2,000 words or less, with up to four original images and/or figures. In general terms, PowerPoint graphics detract from the quality of presentation and should be avoided.

Images and Copyright

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Authors must provide a 'for correspondence' email address with any article submitted. This will be published alongside your article.

References

JASGBI is not a journal of reference and we can neither encourage nor support long lists of references. In general terms, we will publish no more than ten relevant references.

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