CORESS

Confidential reporting system in surgery

CORESS Feedback

doi 10.1308/003588407X232224

This edition includes a case (36) about which many surgeons will already have a firm view based on their own experience. The purpose of CORESS Feedback is ***not*** *to tell surgeons what to do. It is simply to draw attention to lessons learned from the experience of others and give readers the opportunity to consider their own practice in the light of such experience. CORESS is grateful to all those who have recently sent reports. Some hospitals now regularly select cases to report at their monthly M & M meetings. The on-line reporting form is on our website <www.coress.org.uk> which also includes all previous Feedback Reports.*

Disposable or not? (Ref. 36)

We recently changed our supplier of linear cutting staplers, initially using the new stapler under supervision by a representative of the company. Our usual technique is to insert the limbs of the linear cutter into the two free ends of the bowel and activate it. This divides and staples the adjacent loops to create a side-to-side anastomosis with an open end. We then replace the cartridge and apply the linear cutter transversely across the open end of the anastomosis. The instrument is activated again and this cross staples the open end of the anastomosis, simultaneously amputating any redundant bowel.

After the change of supplier, we experienced unexpected anastomotic leaks from the cross stapled end as well as two haematomas. The manufacturer subsequently advised us that its linear cutting replacement cartridges are not suitable for sealing the blind end and that a second knifeless stapler should be used.

Reporter's comments

A linear cutting stapler is commonly used in this way to make an anastomosis. Although it is not mentioned as a contra-indication in the manufacturer's leaflet, we now learn that in the opinion of a major manufacturer, the linear cutter should not be re-used to cross staple the anastomosis without significant risk of leakage. We have been advised that a second knifeless stapler should be used with consequent cost implications. Also, it cannot be assumed that supervision by product representatives will ensure the use of like-for-like devices, or will avoid mishaps.

CORESS Expert's comments

The Advisory Committee was most grateful for this report that raises an issue of which some surgeons will perhaps be unaware. CORESS approached the two major suppliers of linear staplers in the UK and the following comment was agreed: '*We do not recommend stapling with a linear cutter to close the common entry point of a stapled anastomosis because of the risk of disruption of the staple line by the sliding blade of the linear cutter*'.

The Reporter quite correctly notes the absence of any contra-indication in the manufacturer's leaflet, but surgeons using these instruments might wish to reflect on their technique and consider discussing the matter with the manufacturer concerned.

Surgeons are ultimately responsible for the choice and limitations of any instrument or device they use and it is essential that they are actively included in any decision to change instruments or suppliers. It cannot be assumed that similar instruments are compatible or can be used in the same way and it is unwise to rely on a product representative for safe use.

Wrong patient – or wrong list? (Ref. 37)

When I am on-call, I am now rarely on with my own team and continuity of care is solely at consultant level. One night recently, a girl was admitted with appendicitis and was listed for appendicectomy on the emergency list after a boy who had come in the previous evening with a similar diagnosis. Early the following morning, I informed the theatre staff that I would be available to start with the boy, who I had already seen. Before I reached theatre, I was bleeped and informed that the girl had arrived in the department as the boy 'was not ready'.

Although the 'checklist' was complete and entirely in order, this girl had not been seen by any of the surgical on-call team operating that day,. I examined the child and instructed that she be returned to the ward as appendicectomy was unnecessary.

CORESS
Confidential reporting system in surgery

Wrong patient – or wrong list? *(continued)* (Ref. 37)

Reporter's comments

The surgical shift system that has been enforced upon us in order to comply with the New Deal and the European Working Time Directive is not conducive to continuity of care. In this case, it resulted in a night registrar listing a patient for theatre who could have been anaesthetised without being seen by the operating surgeon. The NHS checklist does not ensure that the operating surgeon has met the patient. I believe that the checklist should be amended accordingly. There was also poor communication between theatre staff and the operating surgeon, as the order of the list was changed without consultation.

CORESS Expert's comments

The Advisory Committee considered that, though not ideal, in very urgent cases it can be acceptable for the operating surgeon to see a patient for the first time in the anaesthetic room. Shortcomings with communication and handover has featured in previous CORESS Feedback (June 2007, Case 34) and is addressed by The Royal College of Surgeons of England (*Safe handover*, Guidance from the Working Time Directive working party, March 2007) <http://www.rcseng.ac.uk/publications/docs/publication.(2007-05-14.3777986999/view?searchterm=SAFE%20HANDOVERS)>.

It's your name on the publication (Ref. 38)

I edit a multi-author surgical textbook which is proof-read by the contributing authors prior to a final reading by the publisher. After the final publisher's proof reading, I was sent a list of drugs which had been named differently in different chapters and sometimes even within the same chapter, despite proof reading by the contributors. Even more serious were errors of dosage. For instance, different units of dosage were used by different authors and one contributor recommended a dose that was grossly excessive. It transpired that, quite coincidentally, the publisher's proof-reader had worked for some time in a dispensing pharmacy and had picked up potentially dangerous errors which had been missed by the contributors.

Reporter's comments

Surgical authors should use generic terminology and not rely on the publisher's proof-reader to correct errors – they are responsible for the accuracy of what is published under their name. This should also be a lesson to those who use surgical textbooks to find the correct dosage of drugs – local anaesthetic, for instance.

CORESS Expert's comments

The Advisory Committee agree. Although it is good practice for a medical publisher to include a statement recommending referral to the drug manufacturer's data sheet (S.P.C.), authors are responsible for the accuracy of their contribution. Responsibility for prescribing rests with the prescriber. In the event of a claim, evidence of referral to the S.P.C. or the British National Formulary would constitute a reasonable defence. Relying on a single (erroneous) entry in a text book would not normally form the basis of a defence likely to succeed.

Stuck fast (Ref. 39)

I had been doing a hernia operation in a private hospital on a Saturday morning and I was in a hurry to get away. We prepared the groin in the standard manner using a brand of disposable drapes with a particularly strong adherent sticky edge. The sticky edge of one of the drapes was inadvertently in contact with the shaft of the penis. The operation was uneventful and as I was dressing the groin I pulled the towels off to avoid some blood getting on to the dressing. I was not careful enough doing

CORESS

Stuck fast (Ref. 39)

this and used too much force. It produced a small abrasion on the skin of the shaft of the penis because the towel had stuck to it. Fortunately, it healed satisfactorily and the patient accepted the apology.

Reporter's comments

Know your drapes. Some varieties of sticky drape are more adherent than others and pulling off sticky edged drapes too vigorously can result in skin damage particularly in certain areas where the skin is thin or delicate. When using these drapes in the groin, care must be taken to protect the genitalia.

CORESS Expert's comments

The Advisory Committee would only add that the skin of small infants and elderly people can be damaged by adherent drapes, irrespective of the care used in removing them.

Flushed with spirit? – Not quite (Ref. 40)

A central venous line was being inserted in the operating theatre under local anaesthetic. The skin was prepared with clear surgical spirit which had been poured into a plastic galipot. Heparin saline had been poured into a similar galipot and was nearby, but at the back of the trolley. The radiographer was detained in another theatre and this caused considerable delay before the position of the guide wire could be checked. During this time, the original scrub nurse handed over to another. After the line had been inserted, the surgeon asked for heparin saline to flush the line. The scrub nurse drew up the remaining surgical spirit and handed it to the surgeon who connected it and was about to flush the line when the mistake was recognised.

Reporter's comments

Clear spirit preparations are dangerous as they can be confused with other fluids and, if used for skin preparation, should be discarded after use and not replaced on the trolley. Perhaps all spirit preparations should be coloured to avoid this risk. Identical containers without labels should not be used. This case also illustrates the potential risks of scrub nurses changing over during a procedure.

CORESS Expert's comments

The Advisory Committee was grateful for this very courageous report and agreed with the Reporter that all clear skin preparations are potentially dangerous in these circumstances, especially surgical spirit, which carries additional risks. The Committee questioned the justification for using spirit to prepare the skin when safer aqueous preparations are now available. In any case, skin preparations should be coloured and there should never be two unlabelled containers on a trolley at the same time. All unused skin preparations, of any sort, must be discarded after draping. The Committee also thought it very unusual for the scrub nurse to change over during such a relatively short procedure.

Surgeons should be aware that clear protocols exist for safe peri-operative practice (*Standards and Recommendations for Safe Perioperative Practice 2004*; Edited by John Beesley and Susan Pirie, NATN; Published by NATN, October 2004. Also <www.afpp.org.uk/publications_list.cfm>). If a patient suffers injury in the circumstances illustrated above, disciplinary and legal action will certainly follow and, at the worst, a prosecution for manslaughter can be expected. If you are going to use it, know what it is!

Finally

Durable?

The Medical and Healthcare Products Regulatory Agency has received a number of reports of the tips of spinal needles breaking off during use when the stylet is not present. Users should be aware that these needles are designed to be inserted (and moved after insertion) with the stylet in place – as highlighted in the manufacturer's instructions.

Reprinted from *One Liners* (Issue 48, March 2007) with the kind permission of the Medical and Healthcare Products Regulatory Agency.