



CORESS – A confidential reporting system for surgery

At a time when the ‘blame industry’ is in overdrive, 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. The answer, of course, is that if this proposal is simply another layer in the clinical governance framework, then it is unlikely to achieve support. So, what is different about this reporting system and why has the Association received universal encouragement since launching CORESS last year?

The purpose of CORESS is, exclusively, to share lessons learnt from unexpected or adverse incidents in surgical practice. It is similar to a system set up for aviation in 1982 following several high profile accidents. The Association has been greatly 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. First, 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 complimentary to existing statutory, professional and organisational measures for the protection of the public and 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 set by the ASGBI and overseen by an independent board.

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 or surgical trainee, irrespective of specialty, can submit reports, in confidence, to CORESS. Reports can be made ‘online’ or by mail, using

a form which can be downloaded from the same website. Reports may concern any safety-related incident involving the reporter, other people, a hospital or other organisations that 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 may often be learned from incidents which 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 is fundamental to the concept of the CORESS service. On receipt of a report, 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* and the ASGBI newsletter, and also distributed to other interested bodies. Whether or not the report is incorporated into the published feedback, the reporter is informed of the advisory committee’s comments and the proposed outcome. The original report is returned to the reporter and all identifying data securely deleted from the CORESS system before any feedback publication.

How does CORESS contribute to safety? Unlike the National Patient Safety Agency, CORESS does not systematically analyse and feedback information to NHS organisations. There is no point in duplicating this necessary and large-scale project. 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 which surgeons have always valued but have, perhaps, felt less able to use in recent years. CORESS gives us a new opportunity to share our experience and asks for your support.

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Editor-in-Chief

CORESS feedback

The Editors are grateful to the Association of Surgeons of Great Britain and Ireland (ASGBI) for allowing the following CORESS vignettes, which had previously been published in the ASGBI newsletter, to be reproduced as examples in the *Annals*.

The two cases this month illustrate a potential problem familiar to all surgeons who operate within the abdomen. We at CORESS are most grateful to the reporters who took the trouble to write in. The continued success of the project depends on you to tell us about your mistakes and near-misses and about lessons learned. We hope you will persuade your trainees to do likewise – CORESS is an educational service for all surgeons irrespective of grade.

The development of the project is going well and we are very pleased to say that there is now a dedicated website <www.coress.org.uk> with details about the project and where a CORESS Reporting Form may be downloaded. In addition, there is the facility to report your cases to us online. Many of you will prefer this method of reporting and we hope to hear from you soon!

We seek it here, we seek it there (1)

A lady presented to my clinic with a large rectosigmoid carcinoma which CT showed to be involving the right ureter and causing a right hydronephrosis. A stent was inserted into the right ureter and 'down staging' radiotherapy given. Two months later, a further CT showed two small metastases in the liver, but the rectosigmoid primary had greatly reduced in size. After MDT discussion, it was agreed that an attempt should be made to remove it prior to appropriate management of the liver metastases.

At laparotomy, the tumour was mobilised quite easily from the right ureter which was still stented. The left ureter was identified at the pelvic brim and traced proximally and distally a short distance. The inferior mesenteric artery was then separated with some difficulty from the presacral fascia and aortic bifurcation due to radiation fibrosis. The artery was divided and ligated and, at this point, I realised that

the left ureter had been divided with the artery. It was apparent that the left ureter had become adherent to the artery as a result of the radiation fibrosis. The two ends of the ureter were rejoined by a urologist who happened to be in the hospital at the time.

Subsequently the patient made an uneventful recovery and went home.

Reporter's comments

Many years ago, I assisted a registrar who divided a left ureter adherent to the inferior mesenteric artery, in similar circumstances, without either of us being aware of this until the damage had been done. I regret having made the same mistake twice but am reminded that the ureters may be very difficult to find when displaced from their normal position by fibrosis or inflammation and are then at particular risk of injury.

We seek it here, we seek it there (2)

A large and very vascular tumour was identified pre-operatively lying between the aorta and left kidney with multiple arterial branches from the aorta and large veins draining into the left common iliac vein and the IVC. The left ureter was not within the tumour but, retrospectively, was clearly within this very vascular bundle.

At operation, the tumour was mobilised from the left kidney and arterial supply ligated. Aware of

the risk to the ureter, the very large venous pedicles were ligated carefully but, on dividing, a pedicle thought to be venous the left ureter was partly transected. The injury was immediately recognised and, as no urologist was available, the ureter was repaired by the operating surgeon.

The tumour was successfully resected and the patient suffered no ill effects from the ureteric injury.

We seek it here, we seek it there – *continued***Reporter's comments**

Pre-operative ureteric stent placement would have avoided this complication. I routinely employ this technique when operating on inflammatory abdominal aortic aneurisms but did not consider it in this case. My practice has changed as a result of this experience and I now stent the ureter whenever it is at risk in abnormal tissues.

CORESS expert's comments

Both these cases illustrate the need for constant vigilance, particularly in difficult circumstances, when any retroperitoneal dissection is performed. The ureter is commonly tethered to the large bowel in inflammatory or neoplastic disease. It may also be displaced medially and become adherent to midline structures in the presence of retroperitoneal fibrosis however caused. How far should the ureter be exposed to identify and safeguard it? The current view is to avoid extensive dissection, especially after radiotherapy, as the blood supply is tenuous and strictures are common

in these circumstances. Many surgeons would agree that pre-operative stenting is a sensible precaution when predictably difficult surgery puts the ureter at high risk of damage. Although this practice may aid identification, it cannot be relied upon to prevent injury if the ureter is not recognised, for instance when buried in dense scar tissue.

Sadly, ureteric damage can occur even in the most experienced hands. The outcome then depends on proper management. These cases could be regarded as success stories! Above all, the damage was recognised at the time. Clearly, if ureteric injury does occur, the ideal is to enlist immediately the help of an experienced urologist who can perform the necessary repair. If, of course, an urologist is unavailable, the operating surgeon will have to resolve the situation. Every general surgeon should be able to repair a cleanly transected ureter. Can you repair a ureter? Is direct repair always possible or appropriate? Might it be a good idea to have a cup of tea with your friendly urological colleague and agree a strategy before this happens to you!



More issues per year

The Editors are delighted to announce that the Council of The Royal College of Surgeons of England have agreed to allow an increase in the number of issues of the *Annals*, from six per year to eight per year. In due course, this will significantly reduce the time from acceptance of an article to its publication and enable us to reach our target of publishing articles within 6 months of acceptance. The Editors are committed to ensuring that only the highest standard of articles will continue to be published in the *Annals*.

Irving Taylor
Editor-in-Chief

