

coress feedback

CORESS feedback

This series of reports draws attention to system errors and communication problems. The second recent report of a retained gallbladder specimen bag, during laparoscopic cholecystectomy, highlights the fact that specimen retrieval bags *must* be included in the operative count. The National Safety Standards for Invasive Procedures address retained foreign objects, and provide a framework to reduce the risk of adverse incidents and ‘never events’. All National Health Service trusts in England should have adopted these standards. Surgeons should be familiar with local protocols for dealing with patients who present with a latex allergy in order to reduce risk of occurrence of this rare but potentially fatal complication.

We are grateful to those who have provided the material for these reports. The online reporting form is on our 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 portfolio documentation.

Delayed diagnosis

(Ref 232)

A 65-year-old woman presented to the emergency department (ED) with abdominal pain. An erect chest x-ray, to exclude free gas, was ordered by the ED doctor but using someone else’s electronic log-in code. The x-ray results, which indicated a right paratracheal soft tissue mass, were reported three days later by the middle grade radiology registrar. By this time, the patient had already been discharged with a four-week follow-up appointment.

The chest x-ray report was only verified a further four days later by the consultant radiologist, who commented: ‘Differential diagnosis is lymphadenopathy or azygous vein – CT recommended.’ The report was not given an ‘amber’ designation, which would have resulted in it being expedited to the consultant responsible for the patient.

The patient’s consultant received the chest x-ray report four weeks after the patient’s admission. He reviewed the discharge summary, which had documented a four-week follow-up appointment, and opted to wait for the outpatient review before booking CT. Unfortunately, the patient missed that appointment and was booked for a further appointment, seven weeks thereafter.

In the interim, the patient was admitted as an emergency to the surgical admissions unit, at which time the missed chest x-ray was reviewed. Urgent CT was finally obtained

ten weeks after the initial x-ray, which had first highlighted the anomaly. CT confirmed a necrotising lung carcinoma.

Reporter’s comments

A number of factors contributed to the excessive delay in diagnosis:

- > Inappropriate use of someone else’s log-in to request the original chest x-ray and no review by the doctor ordering the investigation
- > Delays in reporting and verification of the x-ray report
- > Failure to categorise the clinical information as important (‘amber’), which would have resulted in direct notification of the responsible consultant
- > Decision by the responsible consultant to await patient review before ordering CT
- > Missed outpatient appointment and delay in organising a further appointment

CORESS comments

There were significant system errors in this case. There was not a clear pathway to flag up important radiological findings or to act on them. There was inherent responsibility of the consultant radiologist to ensure that the appropriate clinician had been informed and for the consultant responsible for the patient to act on this information. Although the outcome for the patient may have been no different, the quality of the patient’s care was impaired by these system failures.

Laparoscopic confusion

(Ref 233)

As part of a planned theatre serial upgrade, new high definition (HD) laparoscopic equipment was ordered and introduced into the first of our colorectal operating theatres. A HD stack was complemented by a slimline HD scope connected through a unique coupling. After initial usage, the scopes were sent to the central sterile services department and sterilised. Unfortunately, the new scopes were not labelled or differentiated from the older equipment and the inevitable occurred: at the next theatre list, both laparoscopic theatres ended up with incompatible scopes and stacks, resulting in operative delays with anaesthetised patients on table before the appropriate pieces of equipment were reunited.

Reporter’s comments

At the end-of-list team debrief, all concerned parties were informed, and the scopes were separated and labelled

distinctly. All staff should be briefed on new equipment when it is introduced into the operating environment. Had this been done pre-emptively, the confusion and operating list disruption would not have arisen.

CORESS comments

All operative equipment should be checked prior to anaesthetising the patient. This should form part of the preoperative briefing and equipment check. There is a danger of similar problems arising if formal checklists are not followed effectively.

Conflicting communications (Ref 234)

A patient had been admitted over the weekend with a first presentation of uncomplicated diverticulitis. She had been diagnosed by computed tomography and started on intravenous antibiotics. The consultant in charge of her care had seen her the previous day and advised nil-by-mouth for 24 hours with intravenous maintenance fluids.

On review during a busy morning ward round, I found her in bed but otherwise comfortable and no longer in pain. I explained her diagnosis to her, said that she could now have what she liked to eat, that we would switch to oral antibiotics and that she could go home when she felt ready. She asked what kind of food she could eat to prevent further attacks of diverticulitis, and I told her about low and high fibre diets for symptom control in the short and long term.

I then moved on to another patient. When leaving the bay, I asked the nurse why the patient was still in bed late in the morning and said that she should be encouraged to sit out if possible. The patient was discharged the following day. Later the same month, I received a complaint by email regarding this lady.

The patient's complaint described how she had felt, having received conflicting advice from me and from the consultant on her initial admission. She perceived that she had been forced out of the hospital despite persistent symptoms.

From the patient's point of view, when seen by me on the ward round, she had just come out of the shower and was lying on the bed as she felt a little light headed. Her consultant had told her that she had to remain nil-by-mouth and on intravenous antibiotics for at least a week, and that this would be the only way for her to get better. My later advice contradicted this. Furthermore, she felt that my dietary advice was unhelpful and dismissive of her desire to prevent any further attacks. Finally, she also overheard my conversation with the nurse, 'ordering' her to 'get that patient out of bed!'.

Reporter's comments

I think that this incident could have been prevented by me taking more time to assess how the patient felt and what her anxieties were. This might have prevented the conflict of advice and the patient's confusion. Dietary advice can be addressed easily with leaflets and on a busy ward round, this job could have been delegated to dietitians. I obviously need

to take care with how I 'encourage' patients to mobilise and to note that remarks I make may appear insensitive.

CORESS comments

This case relates to human factors. CORESS appreciated this reporter's frank contribution and obvious insight into a case in which there were problems of communication. On a pragmatic basis, during a busy ward round, there may need to be clinical prioritisation, meaning that fitter patients are seen more promptly. One CORESS Advisory Committee member stated that waiting for an overstretched dietician's advice prior to discharge was living in 'cloud cuckoo land'.

There is a skill to ensuring that patients are satisfied that their problems have been addressed and that these have been explained to their understanding, however brief the contact. It is beyond the scope of this response to discuss communication issues in depth. These skills continue to be developed throughout a surgical career. Advisory Board members made the following comments:

Checking the depth of the patient's understanding of their condition (and what they have been told) is important on first contact. Open-ended questions may form part of this strategy. (Writing a management plan in the notes aids clinicians who subsequently review the patient.) Gauging the emotional response of the patient, and pitching advice at a level to meet his or her needs, helps understanding. Allowing the patient to ask questions facilitates this. Being aware of potential cultural differences that may influence interaction, helps when imparting advice. Do not talk to others about the patient in third person terms within the patient's earshot.

Retained specimen bag during laparoscopic cholecystectomy (Ref 235)

I was undertaking an emergency laparoscopic cholecystectomy in the late evening on a patient with acute cholecystitis. I encountered difficulties removing the gallbladder and phoned my consultant for assistance. He came in from home, excised the gallbladder and placed it in a specimen retrieval bag. We achieved haemostasis and he then left the table to write the operation note, leaving me to complete the procedure. The laparoscopic incisions were closed and the patient was discharged home two days later.

Two weeks thereafter, the patient was readmitted with abdominal pain and fever. Computed tomography demonstrated a right subphrenic abscess and the specimen bag above the liver. At laparotomy, the bag containing necrotic gallbladder and gallstones was removed. The patient required a ten-day hospital stay before she was fit for discharge.

Reporter's comments

This incident arose because of communal failings on behalf of both surgeons and the scrub team. The trainee could not see the bag containing the specimen in the operating field when he re-took control of the procedure and was distracted

by other tasks involved in completing the operation. The consultant was unaware that the trainee had not removed the specimen bag with the gallbladder at the end of the operation and did not check although in anticipation, he had written an operation note documenting this. The specimen bag had not been included in the count and scrub staff did not comment on its retention. A pathology form was written out but a specimen was never sent and this was not highlighted to the surgical team at the time.

CORESS comments

This is the second (almost identical) account of a retained gallbladder, a ‘never event’, in recent CORESS cases. (See case 228.)¹ All objects or equipment introduced into a bodily cavity should be included in an operative count and counted out on completion of the procedure. The members of the operating team have a joint responsibility to ensure avoidance of retained foreign objects and this is covered concisely in the National Safety Standards for Invasive Procedures.

The team brief aids communication between team members and all staff should feel empowered to express concern about aspects of patient safety. When control is handed from one individual to another during an operation (as in-flight instruction), the first surgeon should ensure that the second surgeon understands the task in hand and knows what components remain to be completed. ‘Read-back confirmation’ might help to ensure this. The sign-out at the end of the procedure should have picked up this specific oversight but this remains a woefully neglected part of the World Health Organization surgical safety checklist.

Reference

1. Retained gallbladder at laparoscopic cholecystectomy. *Ann R Coll Surg Engl* 2017; **99**: 589.

Colostomy bridge calamity in patient with latex allergy (Ref 236)

A patient was admitted for a revision of an antegrade colonic enema procedure and formation of a loop colostomy. At the surgical safety checklist sign-in, the trainee involved in the case was present but the consultant surgeon was not. It was highlighted at the sign-in that the patient had a latex allergy as well as at the time-out.

The case proceeded without complication and a colostomy was raised. The consultant asked for a Jacques catheter to be used to make the colostomy bridge and left the operating room. The trainee put the catheter on the patient and made the bridge accordingly but the patient’s blood pressure dropped precipitously. There was a severe skin reaction. It took the trainee a number of minutes to discover that the red Jacques catheter was made of latex. On realising this, the catheter bridge was immediately removed, the skin was washed and the patient subsequently made a good recovery following appropriate management for anaphylaxis.

Reporter’s comments

The absence of the consultant at the sign-in may have contributed to this incident. This case should have been flagged up when discussing the operating list during the team briefing at the beginning of the day, before the sign-in took place. The red Jacques catheter is labelled as being latex positive. However, this was not recognised by the nursing team or by the trainee. Rapid action by the anaesthetist, responding to anaphylaxis, saved the patient’s life.

CORESS comments

When a patient is identified as having a latex allergy, all steps in the potential management of that patient in the theatre environment should be considered at the team briefing and ideally prior to the day of the operating list. The National Safety Standards for Invasive Procedures state that the operating surgeon should be present at the sign-in. Hospitals should develop local protocols that deal specifically with the management of latex sensitivity and there is a case for identifying this issue as a priority concern in surgical training.

Inexpensive, purpose designed plastic colostomy bridges exist. Using equipment for a purpose for which it was not designed or licensed breaches standard operating procedures.