SURGICAL SAFETY UPDATE

Cases from the Confidential Reporting System for Surgery (CORESS)

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Lack of communication in patient discharge

A 63-year-old man with diabetes, chronic stage-3 kidney disease and ischaemic heart disease was admitted with a necrotic fifth 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 two 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 eight days postoperatively with spreading sepsis and subsequently required amputation of three 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. Although 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 patient's discharge and community care. Regular team meetings of all involved in surgical patients' care – surgeons, nurses, physiotherapists and occupational therapists – foster team spirit 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 that arose as a result of poor communication.

Consequences of service disruption during the COVID-19 pandemic

A 64-year-old man presented with a mixed arteriovenous lower-leg ulcer. Duplex ultrasound and CT angiography confirmed mild deep venous incompetence and a 10cm superficial occlusion of the femoral artery. He underwent femoral artery angioplasty and placement of an uncovered stent. This action improved the indices of ankle brachial pressure, thereby allowing him to be placed in four-layer graduated compression bandaging to treat the venous component of his ulcer.

Stent surveillance by duplex ultrasound would usually have been undertaken at routine three-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 four 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 hospital-acquired COVID-19. His respiratory function deteriorated rapidly, necessitating ITU admission. He developed further thrombotic sequelae of COVID-19 and SIRS, with digital necrosis of fingers, which required a prolonged stay on the ITU.

CORESS comments

The impact of COVID-19 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.

Too slick by half

A trainee surgeon, aiming to expedite a morning day-case list by efficient management of paperwork, pre-completed the consent forms for the five 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 reaffirm 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.

We are grateful to those who have provided the material for these reports.

The online reporting form is on our website, coress.org.uk, which also includes 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.

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