

CORESS FEEDBACK

Mr Adam Lewis demitted office as Programme Director for **CORESS** at the end of May 2008. Adam has overseen the instigation and development of the **CORESS** process and has been instrumental in increasing awareness of **CORESS** and in the preparation and distribution of Feedback reports. The Board of Directors and the Advisory Committee would like to record their gratitude to Adam for all his hard work during the last three years and to wish him well in his other endeavours.

Mr Frank Smith, Consultant Surgeon at Bristol Royal Infirmary, has been appointed as CORESS Programme Director with effect from 1st June 2008.

This edition of **CORESS** Feedback includes two cases which vividly illustrate the extent of Consultants' responsibility for effective administration of their practice, both within the NHS and in independent practice. As ever, we are most grateful to the surgeons who allowed us to publish these reports for the benefit of their colleagues. The value of **CORESS** to us all is dependent on the surgeons who are prepared to support the programme by sending such reports. The on-line reporting form is on our website www.coress.org.uk which also includes all previous Feedback Reports.

AN OPEN MOUTH!

(Ref: 51)

As part of a "waiting list initiative", I recently removed a small facial lesion from an NHS patient in a private clinic. The patient, who was well known locally, had very poor oral hygiene. At the end of the day the nurse, employed by me, went to a nearby coffee bar and discussed this in considerable and uncomplimentary detail with her boyfriend. Unfortunately, a close friend of the patient was sitting nearby and overheard the discussion, realised who the two were talking about and reported the conversation back to the patient. I became aware of the situation when I received a letter from the patient's solicitor saying that legal action was to be commenced against me on the basis that I was responsible for the actions of my staff.

Reporter's Comments:

Although I fully accept that the behaviour described is indefensible, I was under the impression that the NHS bore some responsibility for legal action arising out of treatment of NHS patients. I now learn that as an independent contractor I am responsible for the actions of my staff, even when they are not on hospital or practice premises. It is essential that staff members are properly warned about the need for confidentiality.

CORESS Comments:

The Consultant is vicariously liable for his employee. He should have ensured that she understood the duty of confidentiality, but as the employer he was always going to be answerable for her acts or omissions even if he had provided her with a comprehensive induction course. In some ways he might think himself lucky as a complaint might easily have gone to the GMC who would have taken a very dim view. If this had been a clinical negligence case, due to some error on the nurse's part, the NHS patient may well have sued the referring NHS body but if that had been the case, the NHS would undoubtedly then attempt to recover their losses from the consultant.

ALL MY FAULT!

(Ref: 52)

When my long-standing secretary retired she was replaced by a locum who was, perhaps, under some pressure as she was in the process of moving house. Like many of us, I am very dependent on my secretary to work without a great deal of supervision. When a permanent appointment was made, it was then found that reports had not been filed and even signed letters had not been posted. Although a review of all relevant notes showed that no harm had occurred to patients and, in particular, all positive reports had been acted upon, I was required to attend an inquiry where my management skills were criticised.

Reporter's Comments:

It seems that Consultants are responsible for the work of secretaries even though they have no direct control over them. If there is a mistake then the consultant may be disciplined by local management and this can affect his / her career.

CORESS Comments:

The Consultant is responsible for ensuring that adequate administrative processes are in place so that continuity of care is not jeopardised by failure to review results, arrange follow up, communicate with GPs, refer to another specialist, etc. Efficient administration is an integral part of good clinical care as this case demonstrates. Even if there was a different line management structure for secretarial staff, it remains the Consultant's responsibility to take action if patient care is threatened by inadequate or ineffective support. Cases like this can lead to all sorts of legal consequences including clinical negligence claims, internal disciplinary issues and even referral to the GMC or National Clinical Assessment Service.

URGENT INACTION

(Ref: 54)

A technically difficult restorative proctectomy on a very obese patient took nearly 5 hours. Before leaving theatre I massaged the patient's calves which felt rather indurated although a good dorsalis pulse was palpable. After the post-theatre ward round I returned to the recovery area to review the patient and examined the calves again, finding them more obviously indurated but not swollen. I thought the most probable explanation was a compartment syndrome and spoke to the locum orthopaedic consultant who was on duty and who agreed to check the diagnosis with a pressure transducer. I asked him to do a fasciotomy if he agreed. When I got home I telephoned the hospital and was told that as there were good foot pulses it was not necessary to intervene. I immediately returned to the hospital, and did a bilateral fasciotomy. The calf muscles were very oedematous and immediately bulged out of the wounds. Later the plastic surgeons needed to graft the wounds and it was many months before the patient was walking properly. Fortunately she accepted my explanation and apology for the delay and did not take things further.

Reporter's Comments:

The presence or absence of distal pulses is irrelevant to the diagnosis of compartment syndrome. Operation is needed urgently on clinical grounds and the decision should not be delegated to a junior colleague.

CORESS Comments:

Although reliable data is lacking, the Advisory Committee think that this complication is becoming more common, presumably associated with increasing obesity in the general population. Colorectal surgeons, in particular, might be well advised to review the literature on compartment syndrome after procedures such as this. Preventative measures such as avoidance of stirrups and lowering the legs below the horizontal during the course of a prolonged operation may be useful. Certainly the legs should be checked and the presence of palpable pulses does not exclude the diagnosis. Although it would now be unreasonable to expect a colorectal surgeon to do a fasciotomy, the Committee suggests that it is unwise to leave the hospital, in such circumstances, before ensuring that an agreed management plan has been implemented. The outcome might have been very different here if the colorectal surgeon had been unable to do the fasciotomy herself.

PILLAR TO POST

(Ref: 54)

An elderly patient of mine, with a past history of carcinoma of the colon, was admitted with abdominal pain by the on-call surgical team. A CT and colonoscopy one month before had been clear. Two days after admission he was referred back to me. When I saw him he was grossly dehydrated but not septic. His abdomen was moderately distended but non-tender. Instructions were given for appropriate resuscitation, prior to surgery, which was to be undertaken by the duty team when the patient was adequately prepared. These instructions were passed on to the night team. Over the weekend, the patient was seen by a speciality registrar who was on duty until midday on Saturday and Sunday; the day surgical registrar and finally the night surgical registrar. Each noted that the patient's condition was not improving despite apparently adequate fluid resuscitation. However, none seemed to appreciate the significance of this, nor did they inform the responsible consultant. On Monday morning, I found the patient septic with a peritonitic, rigid abdomen. At operation I found a perforated sigmoid diverticulum but the patient arrested on the table and could not be revived.

Reporter's Comments:

There was a failure of timely resuscitation and referral back to my team after acute admission and lack of effective communication between on call registrars who did not appreciate the severity of the patient's illness. The duty Consultant did not appreciate the inexperience of the junior surgical staff on call. The clinical abilities of junior surgical staff should not be relied upon unless one is familiar with their clinical skills. The Consultant has to adopt a more hands-on approach which may mean more work but is the only way to avoid future disasters. Lastly, the rota system being used at our institution is unsatisfactory and lends itself to these sorts of situations as there is no continuity of care.

CORESS Comments:

The Advisory Committee make no apology for publishing yet another example of the potentially disastrous consequences of dysfunctional organisation and the failure of a Consultant to appreciate the current need for close supervision of trainees. The Committee are grateful to the Reporter for sending this case and can add little to the comments made. Personal handover of seriously ill patients to a Consultant colleague, in writing, is always wise before a Consultant goes off duty. Such patients should be prioritised so that, at weekends, they are seen early each day by the duty Consultant and there should be a clear line of responsibility for the management plan. The Committee are aware that in some countries such "Doctor's Orders" are placed at the end of the patient's bed and are referred to by all staff visiting the patient.

FINALLY ...

MRHA has received reports of tracheostomy tubes falling out due to failure of the securing tabs on the tracheostomy tube holder. The securing tabs had been excessively trimmed by the user, resulting in the stitching falling apart. Care must be taken when trimming any excess material from the securing tabs of the tube holder.

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As Feedback goes to press, MRHA has also informed us that it has received a substantial number of reports concerning failure of surgical staples, leading to serious sequelae such as peritonitis, bleeding and acute respiratory failure (when used in the chest). The automatic reaction when staples do not work correctly is to throw the faulty cartridge away. MHRA would like to encourage surgeons to report such instances and to keep the staple cartridge and stapler so that these can be examined by the manufacturer for faults, which may help prevent future similar problems.