CORESS Feedback

Three of the cases in this issue of ***Feedback*** relate to the failure of either the taking or giving of information. A good clinical history underpins management decisions, and emphasis on providing the general practitioner (and patient) with a comprehensive written discharge summary, describing treatment, is paramount. The final case illustrates, once again, that the role of the WHO check list and the timeout cannot be overestimated in facilitating safe surgery.

We are grateful to the clinicians who have provided the material for these reports. The online reporting form can be found on our website, **www.coress.org.uk**, which also includes all previous ***Feedback Reports***. Published contributions will be acknowledged by a **Certificate of Contribution** which may be included in the contributor's record of continuing professional development.

Frank C T Smith
Programme Director, on behalf of the CORESS Advisory Board

FAILURE TO RECOGNISE ALCOHOL WITHDRAWAL IN BLEEDING PATIENT

(Ref: 123)

A 52 year old man, who had suffered a nasal deformity from trauma sustained many years previously, underwent routine septorhinoplasty. He had developed DVTs in the past, and regular warfarin therapy had been stopped six days prior to surgery. He was covered with low molecular weight heparin in the peri-operative period. Surgery was uneventful.

On the night following surgery, he bled and underwent nasal packing. In the morning, he was stable and warfarin was restarted as he was at risk of DVT. On the second post-operative day, the patient became very agitated, pulled out his packs and bled profusely. He became very disruptive, attempting to discharge himself. Subsequently, he became even more distressed and increasingly difficult to manage, such that the on-call psychiatrist was called. The patient was sectioned and sedated.

However, bleeding continued and surgical staff were not called to the ward. At some point, he went to the toilet and collapsed with a cardiac arrest. The resuscitation team were called and CPR was commenced. After three cycles of resuscitation, cardiac output was restored and the patient was transferred to ITU for support. Subsequently, a CT scan demonstrated acute hypoxic brain injury. A belated, careful history, obtained from the family, revealed that the cause of the patient's post-operative confusion was likely to have been due to acute alcohol withdrawal.

Reporter's Comments:
There was failure to escalate care in a patient with on-going bleeding, and staff failed to recognise an acutely ill patient on the verge of collapse.

CORESS Comments:
In acute bleeding, care needs to be escalated quickly and appropriately. A watch and wait approach is not the right option. Careful assessment is important. In this case, the risk of bleeding was greater than the risk of DVT, and anticoagulation could have been corrected in conjunction with further surgical exploration. Had a comprehensive history been obtained at pre-operative assessment, risk of acute alcohol withdrawal might have been recognised earlier, allowing appropriate management. The patient's disruptive condition may have distracted medical and nursing staff from the potentially more serious problem of continued bleeding.

Specialist advice obtained from the Advisory Board stated the following:

The law on treatment of patients who cannot consent for themselves, or who suffer from acute mental disorder and who refuse consent, or who are incompetent to give consent, is complex, and differs in some respects between England, Wales, Scotland and Northern Ireland. Patients who are suffering from a mental health disorder, and who present a danger to themselves or others, may be detained under the relevant mental health legislation, assessed and treated for that mental disorder and for its physical consequences. However, advice should be taken on a case by case basis on whether the patient is suffering from a mental disorder, as defined within the legislation, and whether treatment can be provided on that basis.

Under different legislation:
Under the Mental Capacity Act in England and Wales, or the Adults with Incapacity Act in Scotland, it is possible for attorneys to be appointed to provide consent on behalf of patients who cannot consent for themselves.

Lastly, under common law, patients who are incapable of providing consent can be treated if that treatment is in their best interests.

To find out more, go to:
www.surgicalindemnityscheme/xyz

ABSENT APPENDIX

(Ref: 119)

A 32 year old female presented as an emergency with right iliac fossa pain and vomiting. She had a medical history of anorexia, bulimia and of laparoscopy for gynaecological reasons at another institution several months previously. On the morning after admission, she was still tender, with rebound pain on coughing. She gave no history of gynaecological or urinary problems. A USS undertaken six days previously had been normal. A CT scan was undertaken which was reported as normal, although assessment of bowel loops was difficult.

With persisting right iliac fossa pain, raised WBC, and elevated CRP, laparoscopy was undertaken for probable appendicitis. No abnormality was revealed in the pelvis, or the small or large bowel. However, where the appendix had been, there was a row of staples across the base. Post-operatively, the patient denied all knowledge of the previous appendicectomy. This patient was unaware she had had an appendicectomy, and a potentially unnecessary procedure was undertaken.

Reporter's Comments:

With the move away from open surgery involving a gridiron or Lanz surgical incision scar, to the generic scars of a laparoscopy, patients should be informed, following the procedure and preferably in writing, of any procedures that have been undertaken laparoscopically.

CORESS Comments:

This problem is not unique to laparoscopic surgery. Patients may not remember, or fully understand, what procedure has been performed for a variety of reasons. It is good practice to give patients a copy of the discharge letter that explains what procedure was undertaken and why. In this case, diagnostic laparoscopy was not unreasonable. It is likely that staples from an appendicectomy would have shown up on the CT scan.

ANTI-EMBOLIC STOCKINGS COMPOUND LEG ISCHAEMIA

(Ref: 127)

A 75 year old woman underwent an emergency Hartmann's procedure for complicated diverticular disease. Three days postoperatively, she complained of pain in her left leg and foot. On removal of her anti-embolic stockings, she was found to have a critically ischaemic leg. The on-call vascular surgeon arranged for magnetic resonance angiography, which confirmed the presence of a superficial femoral artery occlusion. This was successfully treated by angioplasty, but the patient required emergency calf fasciotomies for compartment syndrome. The forefoot remained ischaemic and required partial amputation. On further questioning, she gave a history of progressive debilitating short distance intermittent claudication for two years prior to admission for surgery. No vascular examination of the legs was documented in the admission notes.

Reporter's Comments:

Antithrombotic compression stockings should NOT be applied if there is a history of, or signs of, peripheral vascular disease of the lower limbs. Peripheral pulses should be assessed before prescribing TED stockings. Other factors contributing to ischaemia in this case may have included perioperative hypotension, legs elevated in stirrups and leg oedema.

CORESS Comments:

A comprehensive medical history would have revealed symptoms of peripheral arterial disease, and appropriate examination should have been undertaken. Risks of compression stockings in patients with arterial disease are well documented, and in a patient with a history of claudication, measurement of ABPIs pre-operatively would have been appropriate. A VTE assessment should have been conducted, and perioperative subcutaneous heparin could have been employed as an alternative antithrombotic precaution. In a patient wearing anti-embolic stockings, the legs should be examined regularly in the postoperative period.

SURGICAL MARKING UNSEEN

(Ref: 128)

I was operating on a morning list with three primary inguinal hernias under local anaesthetic, one right and two left. All patients were seen pre-operatively on the ward, consented and the proposed side of surgery was marked. The previous week, I had inadvertently marked a patient close to the incision site, so this time deliberately marked the side of operation higher on the abdomen. On arriving in theatre, I led a team briefing with all the theatre and anaesthetic staff.

The first patient was brought into theatre for hernia repair under local anaesthesia. He was given a small dose of sedation but remained relaxed and orientated. We talked about his family and business whilst I administered local anaesthetic. Once the regional block was complete, we draped the patient and paused for our WHO time-out check. Being awake, the patient even contributed to this by confirming his name and date of birth. It was during this check that a theatre healthcare assistant asked us to stop what we were doing and pointed out that we were about to operate on the wrong side. The pen mark denoting side of operation had been covered by the surgical drapes. I immediately explained to the patient what had occurred, discussed the case with the anaesthetist, and we decided to place the patient at the end of the operating list to allow time for the mistakenly administered local anaesthetic to wear off. His procedure was performed later that morning, without incident.

Reporter's Comments:

Two circumstances led to this error; the mark that I had made, whilst deliberately high to avoid the surgical field, was not visible when I had exposed the patient to administer local anaesthetic. Secondly, the patient was sedated before the time-out check and whilst alert, was chemically disinhibited. The fact that he was conscious and didn't object to local anaesthetic being injected into the wrong side lulled me into a false sense of security. My practice has changed so that the patients are now marked in conspicuous sites on the side of surgery and they are no longer sedated before a final time-out check has occurred. The importance of the time-out check was really emphasised to me on this day, but I believe it was the brief before the list, and the fostering of an environment where everyone felt comfortable to speak up, that really saved the day.

CORESS Comments:

The WHO check list is effective and has been designed to reduce the incidence of adverse events such as wrong side surgery. Its use is strongly advocated. As with any checklist however, there is a danger of overfamiliarity and merely paying lip service to the checks, rather than using them as an effective tool. The value of the time-out check in enhancing theatre team communication is evident in this report. The surgical mark should be visible, even when the patient is draped. Concerns over risks of tattooing from surgical marking combined with incisions are not well founded.