

# coress

## Feedback

This series of cases illustrates potential for errors and adverse events, in cases in which patient care is pooled. This situation is increasingly likely to occur in large Units where care is centralised. Communication is key, and responsibility for the patient's care by individual clinicians must not be avoided or ignored. Situations in which errors have occurred should be carefully analysed so that the systems allowing these can be changed to reduce risk.

We are grateful to those who have provided the material for these reports. The on-line reporting form is on our website [www.coress.org.uk](http://www.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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### RETAINED WOUND PROTECTOR

(Ref: 218)

A self-retaining wound protector was used to hold a wound open during a colorectal operation. The surgeon made the incision slightly bigger and put his hand through the protector to perform a hand-assisted anastomosis. When the patient became unwell a few days later it was found that the wound protector had been retained in the abdomen. A second operation was required to remove it.

#### **Reporters Comments:**

Wound protectors and other surgical items such as ports and gallbladder retrieval bags are often not included in the surgical count. When an incision is enlarged, the wound protector should be changed for a larger

size. It is assumed that the protector slipped into the wound when the incision was enlarged, and was retained under the abdominal wall when the surgeon removed his hand.

All disposables should be included in the count. Just because it is assumed that it would not be possible for something to be retained does not mean it could not happen.

#### **CORESS Comments:**

All disposable items used in the operative field should be counted in, and out. Always check that the equipment being removed from the wound is intact, and that components have not been left in situ.

### TOO MANY GUNS...

(Ref: 217)

During a reversal of Hartmann's Procedure, the rectum and sigmoid colon were found to be very narrow. Intra-operatively, both 25mm and 29mm circular stapler guns were opened and checked to see where they would reach in the rectal stump. Further dissection allowed a 29mm gun (the preferred option) to reach near enough to the stump. A 29mm anvil was placed in the descending colon and an attempt to achieve an anastomosis was undertaken. The gun was placed rectally, the spike extended through the rectal stump and docked with the anvil. The gun tightened as expected, but didn't fire correctly. It then became apparent that the 25 mm gun had been used in the attempt to connect to the 29mm anvil. A further attempt with the correct gun was successful.

#### **Reporters Comments:**

A size mismatch between staple gun and anvil occurred when the wrong gun was used in error. The

design of the gun for this device allows a size mismatch to occur - beware! Ideally only one size of staple gun should be open and available at the operating table at any one time. A visual and verbal check should be undertaken to ensure matching components before the staple gun is fired to form an anastomosis.

#### **CORESS Comments:**

This report suggests a system error in which it was possible to unite two mismatched components. CORESS would like to learn if this situation has also happened to you? If a common occurrence, representation will be made through MHRA to alter the manufacturing process. Colour coding of device components for individual sizes is used for some devices, although even this may not prevent similar occurrences. As per the reporter's comments, only one gun and its specific components should be available in the operative field.

### NO NOTES – INCORRECT PROCEDURE

(Ref: 59)

A patient with whom I had been involved for some years was brought to theatre for closure of a colostomy. She was accompanied by a set of temporary notes, which did not include records of previous surgery. She had been admitted on the day of surgery and consented by the SpR who had not previously seen her, and who accepted her account of the procedure to be undertaken. I realised that the notes were not present when I checked before the anaesthetic and requested them. I had to decide whether to proceed with the operation or send the patient back to the ward.

In the end we undertook surgery and I closed what I had remembered was

a loop colostomy by simple closure of the defect. I was very uneasy about this and told the nursing staff not to send the patient back to the ward until the notes had arrived and I had seen them. Eventually, clinic letters were retrieved and printed off by the secretary. On review it was clear that I had closed an end-colostomy. The patient was immediately re-anaesthetised and I undertook the previously planned bowel re-anastomosis.

Postoperatively I explained what had happened to the patient, who fortunately was very understanding.

#### **Reporters Comments:**

Never undertake a procedure based on memory alone without review of

the relevant clinical records and investigations. Don't succumb to the temptation to cut corners because of work pressures.

**CORESS Comments:**

This situation should never have been allowed to happen. All relevant information must be reviewed prior to undertaking any

procedure. When an operation is being undertaken as a direct consequence of previous surgery, the previous operation records should be reviewed to aid planning of the current proposed intervention. Colorectal surgeons on the Advisory Board emphasised the role of endoscopy if unsure of the anatomy of a stoma.

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## MINI-TRACHEOSTOMY COMPLICATIONS

(Ref: 221)

An elderly female patient had an uneventful right upper lobectomy for lung cancer. 5-days post operatively she began to develop respiratory failure, secondary to retained secretions which she was unable to expectorate. It was decided to insert a mini-tracheostomy tube under local anaesthetic to facilitate pulmonary toilet. The patient was in the intensive care unit (un-intubated) and an anaesthetist administered Midazolam sedation. During the insertion procedure the guidewire became misplaced outside the airway and on insertion of the mini-tracheotomy tube and dilator, a significant injury to a thyroid artery occurred. When the dilator was withdrawn there was massive haemorrhage up the mini-tracheotomy tube, which could not be controlled. The patient lost in excess of 1700ml of blood extremely rapidly and although she was transferred immediately to an operating theatre where local control was achieved by emergency sternotomy, resuscitation was unsuccessful.

**Reporters Comments:**

Poor technique was involved. The guide wire was not in the trachea before dilation began. The procedure was not undertaken in or near an operating theatre in case of haemorrhage, although this complication, thankfully, is rare.

National guidelines on indications for mini-tracheostomy usage and

insertion are lacking. As a consequence of this incident it is now our practice to introduce mini-tracheotomy tubes only in an anaesthetic room or an operating theatre. The procedure is performed under general anaesthesia and commences with a rigid bronchoscopy for bronchial toilet. The rigid bronchoscope is then withdrawn to just below the level of the cords and the mini-tracheotomy tube is introduced into the airway with direct visualisation through the rigid bronchoscope to ensure correct placement of the tube.

**CORESS Comments:**

Mini-tracheostomy should be undertaken in a well-lit operating theatre or anaesthetic room, with facilities and available personnel with expertise to intubate at hand. In many cases general anaesthesia may not be initially feasible, (sedation is usually contraindicated), and the procedure can be carried out under local anaesthesia by experienced staff. A key step in the procedure is to ensure that the Tuohy needle is in the trachea, with free aspiration of air, PRIOR to insertion of the guidewire.

If the patient is severely hypoxic and non-cooperative it may be a wise alternative to intubate, ventilate and opt for early tracheostomy.