coress Feedback

This series of reports highlights system errors and communication problems. The second recent report of a retained gall-bladder specimen bag, during laparoscopic cholecystectomy, highlights the fact that specimen retrieval bags MUST be included in the operative count. The National Safety Standards for Interventional Procedures (NatSSIPs) address retained foreign objects and provide a framework to reduce the risk of adverse incidents and Never Events. All NHS 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 on-line reporting form is on our website www.coress.org.uk which also includes previous Feedback Reports. We will acknowledge published cases with a "Certificate of Contribution", which can be included in the contributor's record of continuing professional development, or may form part of appraisal, or ARCP portfolio documentation.

Professor Frank CT Smith
Programme Director, on behalf of the CORESS Advisory Board

Delayed diagnosis

(Case Ref: 232)

A 65-year old lady presented to the Emergency Department (ED) with abdominal pain. An erect CXR, to exclude free gas, was ordered by the ED doctor, but using someone else's electronic log-in code. The CXR, which indicated a right paratracheal soft tissue mass, was reported 3 days later by the middle grade radiology registrar. By this time the patient had already been discharged with a 4-week follow-up appointment.

The CXR report was only verified by the Consultant Radiologist a further 4-days later, who commented: "Differential diagnosis is lymphadenopathy or azygous vein – CT scan 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 CXR report 4 weeks after the patient's admission. He reviewed the discharge summary, which had documented a 4-week follow-up appointment, and opted to wait for the outpatient review before booking a CT scan. Unfortunately the patient missed that appointment and was booked for a further appointment, 7 weeks hence.

In the interim the patient was admitted as an emergency to the Surgical Admissions Unit, at which time the missed CXR report was reviewed. Urgent CT scan was finally obtained 10 weeks after the initial CXR, 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 CXR and no review by the doctor ordering the investigation
- Delays in reporting and verification of the CXR 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 the CT scan
- Missed outpatient appointment and delay in organising further appointment

CORESS Comments:

There were significant system errors in this case, in which 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 (Case 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 high definition stack was complemented by a slim-line HD scope connected though a unique coupling. After initial usage, the scopes were sent to CSSD and sterilized. Unfortunately the new scopes were not labeled 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 labeled 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 pre-operative briefing and equipment check. There is a danger of similar problems arising if formal checklists are paid lip service to, but are not followed effectively.

Conflicting Communications (Case Ref: 234)

I reviewed a patient on a ward round who had been admitted over the weekend with a first presentation of uncomplicated diverticulitis. She had been diagnosed by CT scan and started on IV antibiotics. The consultant in charge of her care had seen her the previous day and advised nil-by-mouth for 24 hours with IV 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. On 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 on 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 felt 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 IV 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 dieticians. 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 expeditiously. One Advisory Board member stated that waiting for 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 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 their needs, helps understanding. Allowing them to ask questions facilitates this. Being aware of potential cultural differences that may influence interaction, helps when imparting advice. Don't talk to others about the patient in third person terms, within the patient's earshot.

Retained specimen bag during laparoscopic cholecystectomy (Case 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 BertTM 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 later the patient was readmitted with abdominal pain and fever. CT scan demonstrated the BertTM bag above the liver, and a right sub-phrenic abscess. At laparotomy, the bag containing necrotic gallbladder and gallstones was removed. The patient required a 10-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 BertTM bag with the gallbladder at the end of the operation, and did not check, although in anticipation, had written an operation note documenting this. The BertTM 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 gall bladder, a Never Event, in recent CORESS cases (see case 228). 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 operating team have a joint responsibility to ensure avoidance of retained foreign objects and this is covered concisely in the National Safety Standards for Interventional Procedures (NatSSIPs).

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 WHO sign-out at the end of the procedure should have picked up this specific oversight, but remains a woefully neglected part of the check-list.

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

A patient was admitted for a revision of an antegrade colonic enema (ACE) procedure and formation of loop-colostomy. At the WHO sign-in, the trainee involved in the case was present but the consultant surgeon was not. It was highlighted at the WHO sign-in check that the patient had a latex allergy, and also 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 Jacques catheter on the patient and made the bridge accordingly, but at the same time the patient's blood pressure dropped precipitously. There was a severe skin reaction. It took the trainee a number of minutes to discover that, in fact, 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 WHO sign-in may have contributed to this incident. This case should have been flagged up when discussing the list at 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. NatSSIPs 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 sensitive issues, and there is a case for identifying this issue as a priority concern in surgical training.

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