CASE EXAMPLE 1

Missing notes and mistaken identity
A patient, whom I knew well, came to theatre for 'closure of a colostomy'. The medical notes could not be found when I checked the heavily sedated patient in the anaesthetic room (they turned up later having been sent to the X-ray department in another patient's file). It was a busy list, which was only just possible to accommodate in the time available if everything ran smoothly. I elected to proceed with the operation rather than to send the patient back to the ward. It was a mistake. I closed what I had remembered as a loop-colostomy, by simple closure of the defect. Sometime later, the ward sister rang, when the notes had been recovered, having realised that I had, in fact, closed an end-colostomy. The list had been altered and another patient substituted; a man of similar age, who was merely due for refashioning of his end-colostomy. The patient, by this time, was fully recovered. Following a highly embarrassing interview with the patient and his relatives, he was re-anaesthetised the following day and the correct procedure was completed uneventfully. A modest financial settlement resulted.

Reporter's Comments:
This was not the happiest time of my surgical career. I succumbed to that oldest of mistakes; trying to cut corners to squeeze in as much work through an overloaded system, as possible. A change of anaesthetist and busy ward staff, plus a slip in the theatre protocol for altering theatre lists, did not help. The theatre services team have since agreed with my suggestion that under no circumstances will patients for elective surgery be accepted into the theatre suite without full documentation accompanying them, and alterations in theatre lists must be properly documented within the theatres. Regardless of any pressure to the contrary, never feel that you have to proceed with an operation without being entirely satisfied that all necessary documentation and results of relevant investigations are available. I thought that it would never happen to me: but it did. Do not rely on memory alone.

CORESS Comments:
This is a case with an important message. We cannot help but agree with the Reporter's analysis of the underlying problem and the **CORESS** Advisory Committee is grateful for his frank account and recommendations. If it is any small consolation, several other cases of a similar nature, involving errors surrounding closure of colostomies, had been encountered by members of the Advisory Committee. As the Reporter identifies, this is a systems failure, where two of the major built-in safeguards in standard protocols were removed, leaving it all down to that most capricious of faculties, our memory. No operation should proceed without review of the appropriate documentation and, at minimum, the presence of a signed consent form. Most hospitals will have in place several checks in the pathway from the ward to the surgeon's knife. Colleagues are advised to be familiar with them and ensure that they are followed.

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