Portsmouth ASM 2010

Summary of the Workshop Sessions and Debates

Workshop: Organisational Dilemmas in Pre-operative Assessment

Facilitators: Anna Lipp, Jane Montgomery and Mary Stocker

Author: Anna Lipp

This workshop was attended by about 40 delegates, and the subject matter discussed was focussed by questions previously submitted as useful topics for debate. Anna has provided a precis of this valuable session.

- Timing and type of appointments. 'One stop' services (where assessment is carried out immediately after the surgical out-patient consultation) are becoming more important as waiting times reduce and for patients on two week wait cancer pathways. Some patients like 'one stop', while others prefer to have time to discuss potential surgery with their family before their pre-operative assessment (POA) appointment. If 'one stop' is offered, patients should be informed of this possibility when they are sent their surgical outpatient appointment so they are prepared. Similarly, patients could be offered an opportunity to make contact with the POA clinic to ask any further questions later. A mix of booked and one stop facilities offers choice for patients and better utilisation of appointment times.
- Tracking patients who are awaiting tests, results or specialist opinion. A system needs to be in place to ensure patients are followed; electronic systems enable other staff to track patients' status but many still rely on paper notes. Colour coded groups can indicate patients who are ready or pending various outcomes.
- Short notice assessments. While they are not ideal, they may be necessary to fill gaps, or for trauma or emergency cases. Again, any system needs to identify patients with results to be checked/ swabs to be done. Risk of delay or cancellation should be communicated to surgeon/patient.
- POA screening in Primary Care. It was recognised that if this could be established, the patient pathway would be smoother. The provision of basic patient information accompanying surgical referral, for example, blood pressure, BMI, and blood sugar in diabetic patients, is being developed in some parts of the country, but is not yet widespread.
- Physical examination of the heart and lungs by nurses. Few units are doing this and the necessity for this debated. Many felt it would not alter management in absence of symptoms in the patient history.
- VTE thromboprophylaxis. New NICE recommendations relating to Day surgery are not widely implemented yet. There was discussion regarding whether walking out of hospital counts as resumption of normal mobility, but no consensus was reached. Travel advice was also discussed-NICE recommends not travelling more than 3 hours continuously for 6 weeks post op and most adopt this advice.
- Investigations. Many felt that too many were being done to satisfy a small numbers of anaesthetists who demand excess tests. Reference was made to the pilot study published by Chung et al[1],with the results of a larger study looking at outcomes after randomising day case patients to investigations or no investigations expected in due course.

1. Chung F, Yuan H, Yin L, Vairavanathan S, Wong DT. Elimination of preoperative testing in ambulatory surgery. *Anesthesia and Analgesia* 2009;**108**:467–75.

Debate: 'This House believes that suxamethonium should be consigned to the pharmacological graveyard'

Proposer: Prof Ranjinder Mirakhur   Opposer: Dr Mike Copp

Chair: Ian Jackson   Author: Ian Jackson

It was obvious from the outset that Professor Mirakhur would need all his charm and knowledge if he was going to win this debate as in the pre-debate vote, only one person voted for the proposal! Professor Mirakhur initially concentrated on the severe side effects of suxamethonium particularly in fit young people and then moved onto to demonstrating the efficacy of non depolarising alternatives for intubation and sugammadex for reversal. Finally, he attempted to scare the audience about the duration of suxamethonium and the degree of oxygen desaturation that would be present by the time it had worn off.

In reply, Dr Copp naturally played the risk card – scaremongering about the loss (or banning) of suxamethonium from his hospital because Professor Mirakhur had consigned it to the graveyard. He offered several scenarios, examples included those of the patient who had to come back to theatre needing a rapid sequence induction within 24 hours of last dose of sugammadex? What about the risk of the use of non depolarising muscle relaxants allowing trainees longer periods to attempt intubation (perhaps especially in the out of hours period when they don't want to call the boss in) that may risk changing a "Can't intubate - Can ventilate" case into a "Can't intubate - Can't ventilate" scenario.

This was a fascinating debate led by two excellent speakers and though Professor Mirakhur lost convincingly (only 2 voted for the proposal at the end of the debate) I feel that those delegates who missed this session would be well advised to log on to the website and listen to the presentations.

(Summary continues after centre spread)

Workshop: How improving teamwork and communication has a positive effect on patient safety and reducing adverse events

Facilitators: Diane Gilmour, Joan Russell and Trevor Dale

Author: Diane Gilmour

An extremely valuable workshop led by Diane, President of AfPP, Joan, who is the Head of Patient Safety for Anaesthesia and Surgery at the NPSA, and Trevor, a Director of 'Atrainability'. Diane has provided a summary of the workshop that is reproduced in full as part of the ongoing support that the Association is pleased to offer in collaboration with "Patient Safety First".

Many of us consider that we work as a team and an effective one at that. The patient relies on everyone involved with their care knowing what they are supposed to do, knowing their role and what the plan is for each individual patient. How confident are we that we know what to do if an unplanned event occurs? How often does a list or case run smoothly? The quality of outcome and safety of the patient is dependent on us as a team. If plan A – what should happen if all goes well- goes awry do we all know and prepare for plan B? Small errors can occur, accumulate and increase the risk of a major adverse event. Effective team work can prevent this.

Elaine Bromiley tragically died during an attempted operation in 2005. If there had been a plan B – what could have happened, what the warning signs would have been (low saturation levels), how to bring this to the attention of the Consultant Anaesthetist (trigger words/ assertion skills), what equipment would be needed in this eventuality (emergency tracheostomy kit) and who to call for help- then maybe the outcome would have been different.

The National Patient Safety Agency (NPSA) launched the "five steps to safer surgery" as one of their programmes of work for 2010. Their aims are to reduce harm associated with perioperative care and to support a change in culture in theatre teams focussed on improved communication. The five steps including the World Health Organisation (WHO) surgical safety checklist and are:

1. Pre-operative team Briefing.
2. Sign In
3. Time out
4. Sign out
5. Post-operative Team Debriefing

The pre-operative team briefing allows time for all the theatre team members to introduce themselves and empowers more junior members of the team to "speak up" It also details what should happen during the list or the case and if there are any changes, and also highlights any concerns from the members of the team. There is also an opportunity to discuss Plan B which includes equipment, staffing, patient care and warning signs if an unplanned event did occur. The airline industry effectively use a trigger word – a word that is used by all members of the team and which will draw attention to a situation affecting the patient or delivery of their care during that time. This could be 'STOP' or 'CODE BLUE' or another agreed phrase that is accepted and respected by the team. This is now being adopted within Trusts. The briefing can be led by any member of the team and empowers junior members of the team to be more involved in the decisions affecting patient care. The essence of briefing is teamwork, communication and leadership.

Briefings- will it make a difference? Early analysis in England shows that Trusts reported perceived benefits relating to improved teamwork, efficiency and safety but also observed improved staff morale, reduced stress and improved start and finish times enabling additional cases to be scheduled. However this is not universal, and there continues to be a lack of clinical engagement as well as the notion that the checklist is just a tick box which creates barriers and challenges within Trusts[1].

Perhaps the most difficult and least adhered to step of the process is debriefing. The timing, the activity that already happens at the end of a case or list including the anaesthetist managing the patient, and clinicians leaving theatres to write notes, all add to the difficulty facing the team in coming together to debrief. The aim is to ascertain what went well, what could have gone better, what would we do differently next time and even the opportunity to prepare for the next list. It is about learning, not blaming, and fits well with Lean methodology and of course QIPP. However one strategy suggested is that teams are trained to adopt debriefings first. Asking those key questions at debriefing would help teams to recognise that if they had had a briefing many of the concerns, issues which occurred may have been unnecessary events.

Improvements in safety for patients undergoing surgical procedures have been made and building the five steps into every day practice will enhance teamwork, communication and leadership.

Reference

1. Patient Safety First (2010) Implementing the surgical safety checklist . . . The journey so far. www.patientsafetyfirst.nhs.uk

Workshop: Day Surgery under Local Anaesthesia

Facilitators: Cathy Lennox, Harmeet Khaira, Sharon Bell, Deborah Marsh and Alan Stedman

Author: Cathy Lennox

This workshop was an opportunity to explore innovative examples of re-organisation of the surgical team to allow procedures previously done as in-patient to be done safely and routinely as Day Surgery with a strategy of more pre-emptive use of local anaesthetic techniques, supported by new technology.

Also in many cases, the surgeon has adapted to the concept of Day Surgery, such that the surgical repertoire has expanded. Patient expectation has become much more specific, and hospital stays are not inevitable!

Harmeet Khaira described his approach to three very common conditions, for which surgery was previously arranged on an in-patient basis; varicose vein ablation, debridement of the diabetic foot, and inguinal hernia repair.

Using the VNUS closure procedure, tumescent local anaesthetic is delivered by the surgeon, and with the aid of ultrasound scanning, significant varicose veins including avulsions can be dealt with very adequately, with minimal scarring and post-operative pain. Extensive deep debridement of ulceration of a diabetic foot can be performed under local blocks (combinations of digital, metatarsal, and ankle blocks) delivered by the surgeon with the aid of ultra-sound scanning if necessary. Since many such cases are in ASA categories 2 and 3, this is altogether a safer means of achieving adequate excision. Finally, Harmeet explained the potential benefits of the "TAP" block (Transversus Abdominis Plane block), again performed by the surgeon, who has already administered the local anaesthetic, for inguinal hernia repair. The TAP block is performed with ultra-sound aid, (we saw a very clear video demonstration) and provides excellent peri- and post-operative pain control, and patients are very pleased to be able to go home in comfort.

Sharon Bell is a Podiatric Surgeon, who has established an excellent and very popular community-based service for the assessment and surgery of fore-foot problems. The whole service is imbued with innovation, being community-based in a fully-equipped theatre which meets all specifications, the surgeon and team administer the local blocks (usually popliteal block with ankle block as required), with the use of an ankle tourniquet which is extremely well-tolerated by the patient. A range of elective orthopaedic foot procedures are carried out, with contemporary internal fixation techniques. Patient satisfaction is exceptionally high, and the national database (PASCOM) into which all surgical cases are entered, is an exemplar of clinical audit and outcome.

Debbie Marsh and Alan Stedman are Consultant Anaesthetists, who work very closely with their Orthopaedic Hand Surgeon, Sophie Phillips, and gave us an excellent over-view of the evolution and future of Day Case hand surgery in Portsmouth.

Their regular hand surgery operating sessions are very well pre-planned, regional blocks are administered for either short or long acting anaesthesia. Ultra-sound guidance plays a major role in achieving accuracy and appropriate duration of the block for each individual patient. This is a superb example of innovative planning involving surgeon, anaesthetist and surgical team, to achieve maximum throughput, in Day Surgery.

The audience contributed with questions, and some examples of similar initiatives , especially from the Derby Hand Service, whose representatives were very interested in the Portsmouth Hand Surgery experience, and others in the audience who indicated that they would be taking ideas backto their own units. Sharon's description of her service was received with enthusiasm, and some surprise, since it is not replicated in many units as yet, but is likely to become more common.

Harmeet demonstrated the use of the ultra-sound system at the end of the session, and some members of the audience were keen to attend the coaching courses available to learn its use, having been introduced to several of many uses for the technique in Day Surgery.

Debate: 'This House believes that staggered admission times should be introduced for all day case patients'

Proposer: Dr Bill Horton   Opposer: Dr Gerry McCarthy

Chair: Ian Smith   Author: Tim Rowlands

A spirited debate took place in the Council Chambers of the Guild Hall in Portsmouth as part of the British Association Day Surgery 21st Annual Scientific Conference. The motion was "This house believes that staggered admission times should be introduced for all daycase patients". An initial vote on the motion to a packed house was initially narrowly in favour in support. Pragmatic examples of current practise, and an innovative mathematical model made for an engrossing discussion.

Dr Bill Horton, Consultant Anaesthetist in support of the motion, opened the debate. He began by asking the question of whether retaining fixed admissions prior to an operating list we were indeed preserving the obsolete, or whether we could be preparing for the future. Staggered admissions on the day of surgery may improve the flexibility of the operating list and in doing so aim for the shortest possible stay in hospital as part of the patient's journey. By commencing with early morning admission to the daycase unit, with some pre-session priming and then subsequent appointments through the session there would then be minimal impact on those patients waiting, and this in itself built in the flexibility of the session. Dr Horton introduced the concept of "minimally disruptive medicine" using an initial model of interventional radiology; by having staggered admission times one would gain greater occupancy for less space and reduce the need for over-equipped ward areas and actually having fewer patients physically waiting. These measures were in place at his institution, Aintree, with great success.

Evidence from patient-recorded outcome measures observed that the key questions posed by patients have included their position on the list or why they may have waited or starved so long prior to their procedure. Perhaps this could be improved with a minimum-waiting model? Dr Horton sited many examples where staggered admissions have worked and continued to work, such as in general practice, dental surgery, endoscopy and even in veterinary practice and hairdressing.

Dr Gerry McCarthy, Consultant Anaesthetist countered by arguing against the lack of flexibility in staggered admissions by looking at the model of a fixed early admission time for all patients. He argued that this would allow last-minute changes to the list order, which in the ultimate setting of day surgery, he believed would not make a great deal of difference in recorded outcomes. He presented extensive work on this regard and introduced a mathematical model looking at several variables involving patients, procedures, operating times, start and finishing times, amongst many other variables which looked at the overall efficiency of the list in terms of, for example, the procedural time gained versus the time lost in between cases within efficiency measures. The mathematical model showed consistently that a fixed pre-list admission time delivered greater list efficiency when compared to various different permutations of staggered admission times, early list priming and so on. The model and data seemed robust.

A second vote at the end of the two speakers' presentations revealed a swing in favour of against the role of staggered admissions, perhaps somewhat surprisingly; a recommendation was made that though admission to lists may be staggered, in practical terms it made very little difference in the efficiency of those lists in terms of fixed patient arrival time, though it would appear that there is more flexibility in this measure, and greater efficiency.

Conclusion: motion defeated. It seems this area of process remains controversial.

Poster Presentations

Once again, the Poster Exhibition at the Portsmouth ASM was of the highest quality this year, indicating the hard work and dedication of departments wishing to share their commitment to the development of Day Surgery practice. Like last year, the Association wished to recognize the wider efforts of contributors, with the following citations awarded by the Reviewing Committee. Congratulations are due, to not only those authors who are listed below, but also to everyone who submitted a poster, the efforts of whom are formally recorded in the Abstract Book accompanying this edition of the Journal.

Gold Citations

P9: Breast Lumpectomy: Can we Ever Do Too Many and Why? A Mishra, U Khalid, A Taylor, K Chin. Milton Keynes Hospital.

P18: Do Skin Marker Pens Transmit Infection Between Patients? GKG Raghavendra, M Lyall, NR McLean, M Youssef, T Oswald. Wansbeck General Hospital.

P20: Evaluation of Paediatric Tonsillectomy Services to determine if Day Surgery is Feasible. SE Gallagher, TJ Rao, JR Darling, JG Toner. Ulster Hospital Dundonald, NI.

P24: Is Using Oromorph in TTA's useful for patients undergoing day case Laparoscopic cholecystectomy? DJ Portch, GC Werrett, M Hill. Derriford Hospital Plymouth.

P28: Patient Satisfaction Audit of General Surgical Day Case Operations - An Institutional Report. J Younis, A Barnes, T Javaid, HJ Scott. St Peter's Hospital, Chertsey.

P31: Potential Savings from using Oral versus Intravenous Simple Analgesia in Day Surgery Patients. K Lindsay, JV Lodhia, T Blackburn. Withington Hospital.

Silver Citations

P13: Cost Effectiveness and the Choice of Surgical Instruments in Day Surgery: The Role of Surgeons. S Mylvaganam, C Higenbottam, TA Fowler, NJ Purser. Alexandra Hospital, Redditch.

P19: Satisfaction with Pre-operative Assessment and Single Sex Wards. L Harvey, M Ahuja. New Cross Hospital, Wolverhampton.

P23: Introduction of Intravenous Fentanyl for Rescue Analgesia for Day Surgery - The Rotherham Experience. S Unwin, K Russon. Rotherham Foundation Trust Hospital.

P29: Patient Satisfaction with Anaesthesia Care in the Day Treatment Centre at the Whittington Hospital. MC Avanis, R Seneviratne, T Blackburn. Whittington Hospital, London.

P33: Real Time Monitoring - Electronic Portable Audit Device. T Bridge. Surrey and Sussex Hospital.

P38: Unplanned Admissions from the Day Surgery Unit. SC Rowell, DA Blacoe, G Bell. RHSC, Glasgow.

Bronze Citations

P2: An Audit of Day Case Laparoscopic Cholecystectomy. N McCrea. Craigavon Area Hospital, NI.

P4: An Audit of the use of Interscalene Brachial Plexus Block for a Day Surgery Evening List. K.Russon, L.Powell. Rotherham Foundation Trust Hospital.

P5: An Audit on MRSA Screening for Elective Breast Surgery. KV Sigamoney, AK Chatterjee. Burnley General Hospital.

P17: TEP Inguinal Hernia Repair in a DGH - Daycase Rates and Learning Curve. D Dabare, A Barlow, A Maula, DA Ratliff. Northampton General Hospital.

P27: Paralysis is not Mandatory in Laparoscopic Cholecystectomy Surgery. A Mishra, B Keeler, K Toe, P Reed, D McWhinnie. Milton Keynes General Hospital.

P32: Protocols for Postoperative Prescribing: The Way Forward. VU Thanawala, M Layne, J Rozentals, JA Warner, JM Vernon. Nottingham City Hospital.

P34: Laparoscopic Cholecystectomy: Is it Achievable? LJ Tay, N Pore, M Wattie, F Lloyd Jones. Ashford & St Peter's Hospital, Chertsey.