IN CONFIDENCE

A REVIEW OF SURGICAL SERVICES IN HEREFORDSHIRE HEALTH AUTHORITY

A PROJECT COORDINATED

BY

THE KING'S FUND COLLEGE

PART TWO OF THE PROJECT REPORT BY:

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INTRODUCTION

This second section of the report on surgical services in Herefordshire has three parts, Part A includes our observations of practices in waiting list management and admissions policy which caused us concern. Part B concerns practices in the operating theatres which we observed and which give cause for concern. Wherever appropriate, we have made reference to the Joint Memorandum of the MDU/RCN which was included as Appendix 5 of Part 1 of our report. Part C, included here, summarises the main points which arose from our discussions with different staff groups within the Health Authority and which contributed to our understanding of the presenting problem.

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PART A

WAITING LIST MANAGEMENT AND ADMISSIONS POLICY IN GENERAL SURGERY

Specifically we are concerned to note that:

- each of the three general surgeons has a substantial waiting list though it is noted that one is considerably greater in numbers and duration than the other two; (Figure 1)

- there are a considerable number of men of working age who are awaiting surgery for inguinal hernias;

- there are also a number of children awaiting similar operations or surgery for undescended testicles etc;

- no regular comparable reviews of all three waiting lists are made and hence the waiting lists appear longer than they probably actually are;

- patients, who may have been waiting a considerable time for surgery, are given short notices of their admission whereas two weeks' notice should be regarded as an acceptable minimum in such circumstances with three to four weeks a preferred option;

- there is an undesirable practice of asking patients to telephone the ward on the day of admission to confirm that a bed is still available. If patients have already had a long wait they should be guaranteed that there is a bed and an operating space available when they are sent for;

- there is a substantial waiting time for routine new surgical outpatient appointments; (Figure 2)

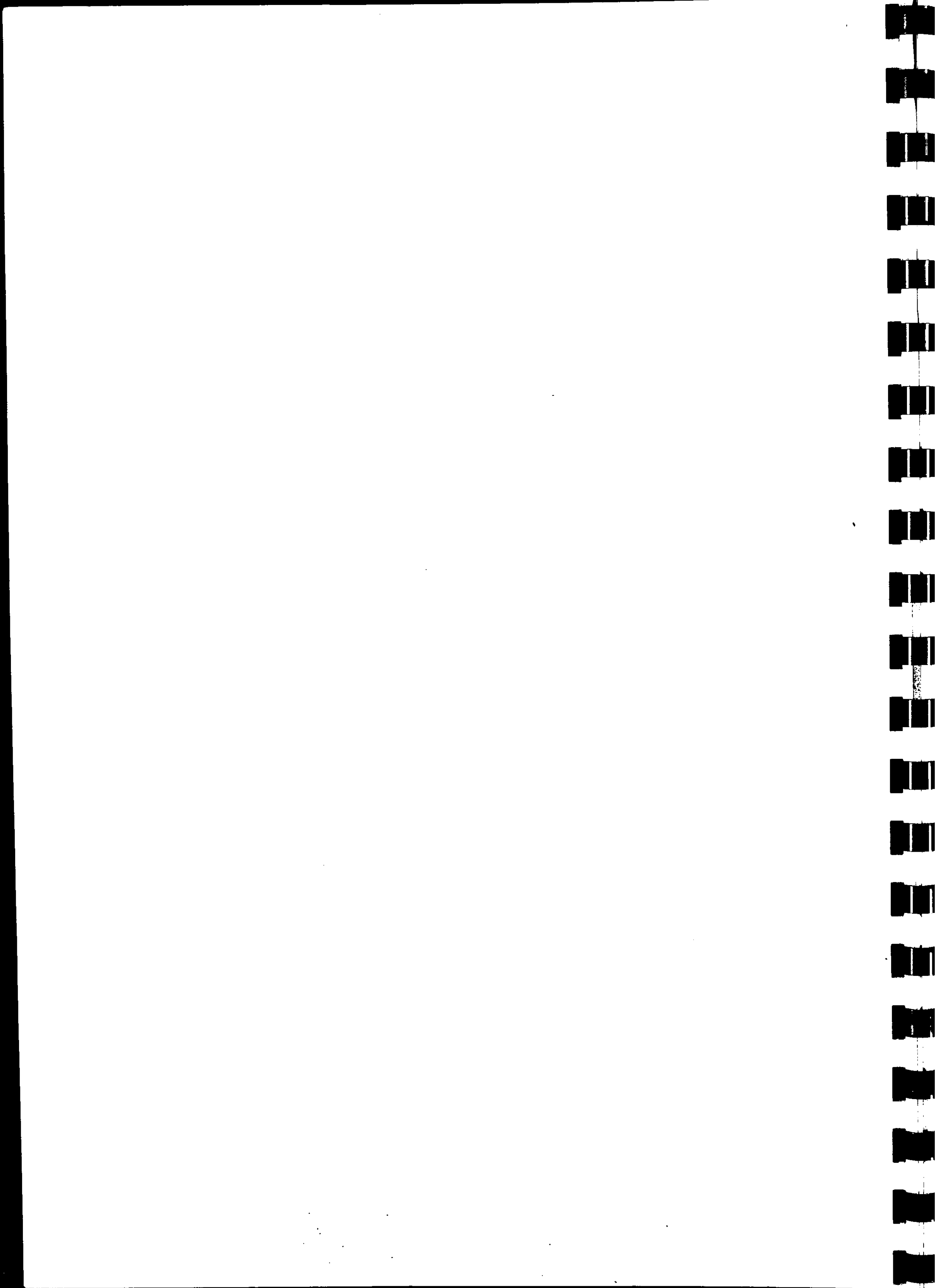
- because one of the consultant general surgeons is at present the consultant member of the DMT, this commitment has further reduced his availability for clinical work (prinicipally outpatient clinics) by 25%;

- there is at times a considerable overbooking of the day case ward with apparently no system to help the consultant staff appraise themselves of the available beds. On one day when we visited the ward 24 patients were booked into 8 beds!

- routine documentation of day case patients was not carried out until they arrived at the ward;

- we noted one day surgery patient who was having an operation under general anaesthesia without a pre-operative examination by a doctor, and learned that this was common practice on one firm;

- we saw a number of instances when planned operating lists were abandoned halfway through because they would overrun a nursing duty period. Provided that the operating list started reasonably promptly and had been properly agreed and notified, we believe it to be unacceptable to treat patients in this way once their surgery has been planned, except in wholly exceptional circumstances.



PART B

PROBLEMS ASSOCIATED WITH PRESENT PRACTICE IN THE OPERATING THEATRES

1 Preparation of Operating Lists

The recommended practice is that one official typewritten list should be prepared and photocopied in sufficient numbers for circulation to the theatre suite, wards, anaesthetic department, haematology and pathology laboratories (reference No 28 Safeguards against wrong operations Joint Memorandum MDU/RCN). The practices observed in Hereford of copying out operating lists onto white boards in theatres and using handwritten patient call slips both introduce a margin for error which the duplication of an official typed copy of the operating list was intended to remove.

2 Changes in the Operating List

These should be avoided wherever possible, but if an emergency occurs or a day patient does not arrive, then the houseman or designated person should ensure that all typed copies of the operating list are changed in theatre suite and on the wards. (Reference No 1.4 and 2.9 Safeguards against wrong operations Joint Memorandum MDU/RCN). It is important that a standardised system for booking emergencies is developed to ensure that all the relevant details are unambiguously provided to the theatre staff at the time of booking.

3 Consent Forms

There should be a standard form used by the medical staff for obtaining the patients' informed consent to undergo operating procedures. These should be used for both inpatients and day patients. Each consent form must be countersigned by the doctor in the patients presence on each occasion. (Reference No 2.7.2 Safeguards against wrong operations Joint Memorandum MDU/RCN.)

4 Patient Identification in the Theatre

A standardised system for receiving and checking in patients arriving from the ward at the theatre must be agreed. This

procedure must then be completed by the theatre nurse and the ward escort as soon as the patient arrives in the theatre suite. (Reference No 1.5 Safeguards against wrong operation Joint Memorandum MDU/RCN). The agreed system should include checking of patient identification wrist band against the typed operating list and all relevant documentation brought with the patient, for example case notes, X-rays, consent form, prescription sheet, etc. This in no way replaces the responsibility of the anaesthetist and surgeon to ensure that the correct patient with completed documentation has been brought to the anaesthetic room. (Reference No 2.12 and 2.13 Safeguards against wrong operation Joint Memorandum MDU/RCN.)

5 Control of Drugs

The procedure for obtaining and recording drug use in the anaesthetic room and operating room should be reviewed and clarified and the responsibility of the nurse key holder for ensuring the procedure is carried out should be identified. The record of the drugs used should include details of the patient for whom they were dispensed and the theatre in which the patient was treated.(Codes of Practice NATN Ch 8, 5.2 B

6 There is an unnecessary potential for error in drug use where ODAs transfer ampules from the manufacturers labelled boxes into a multi-drug holder. Instead a labelled box of each drug needed should be available prior to the list commencing and securely removed at the end of the list. (This cannot occur for controlled drugs which must be checked out as needed for each patient.)

7 Swab checking

The present procedure for swab checking does not conform to the recommendations contained in 'Safeguards against failure to remove swabs and instruments from patients' Joint Memorandum MDU/RCN. Swabs are recorded differently in the gynaecology theatre and the twin theatres. In particular the following aspects of a standard procedure should be pursued:

- A formal checking system must apply no matter how minor or superficial the procedure (reference No 2.1 the above memorandum);

- All bundles should be opened and the swabs counted separately (reference No 2.2 above memorandum);

- The surgeon should ascertain by direct enquiry that all swabs are accounted for before completion of the operation (reference No 2.3 above memorandum).

8 Swab checking

All swabs used by the surgeons should be white and contain radio-opaque material (reference No 3.1 the above memorandum). This is not the case at the moment as green ray-tex swabs are used for D and C and cystoscopy procedures.

9 Swab checking

All swabs used by the anaesthetist and his assistant should be coloured and contain radio-opaque material (reference No 3.2 above memorandum). At present blue swabs which do not appear to have any radio-opaque material in them are used by the anaesthetists.

10 Equipment Standardisation

Instrument checks are complicated by the variety of instrumentation used by each surgeon; there appears to be no standardisation of equipment either in anaesthetic machines, ventilators, light sources or instrument trays. This is both potentially a dangerous situation when junior staff are involved in using or checking equipment, and is also an expensive facility for the Authority to provide and maintain.

11 Equipment checking

A clearly defined checking system for accounting for both loose and atraumatic needles used during surgery should be developed to meet the requirements of items 7.1 - 7.6 in the above memorandum, & Codes of Practice NATN, Ch 22, 5.1 to 5.3.

12 Safe Waste Disposal Procedures

A safe system for collection and disposal of waste mercury and amalgam needs to be developed. At present waste is wrapped in a swab, placed into a rubbish bag and sent off to be burned with medical waste. It is recommended that the advice of the Health and Safety at Work Inspectorate is sought in this respect.

13 Practices associated with Theatre Cleanliness

This needs careful and detailed review as numerous cases of undesirable and unacceptable practices were observed. Some of these are listed below:

- Inadequate cleaning between operations included such practices as the table not being washed, the diathermy leads were not cleaned, walls were not spot washed and sucker bottles were not emptied and cleaned. (Codes of Practice NATN Ch 9 15.1 to 15.3 and Ch 12.)
- Theatre table accessories not in use were frequently placed on the floor of the theatre and were subsequently used on the table without first being washed.

- Inadequate protection of the sterile field was commonplace, for example articles were dropped onto the sterile trolley rather than being placed by the scrubs nurse using a transfer forcep, damaged antistatic table mattresses and other accessory covers were in use despite the fact that once damage occurs there is ingress of fluid which will egress under pressure as the patient is positioned and is a known potential cause of infection.

- Trolleys were pre-set and left in the operating room whilst other operations were taking place and stretcher poles were not removed despite the fact that these can cause pressure on the patient's elbows.

- Bottle brushes were stored in a jar of red fluid rather than being kept dry and autoclaved after use.

14 Staff Clothing

The standards of practice whereby the staff protect the clean zone were hazardous, both to the patients and to the staff themselves. For example, watches, rings, etc were not removed by the staff before entering the clean zone, mask wearing and hand washing procedures were uniformly bad in all grades of staff, surgeons' boots were dirty and food and drink were consumed in the rest rooms by staff in blood stained clothing, despite this practice carrying the risk of hepatitis infection. (Codes of Practice NATN Ch 10 4.5, 8.1 to 8.3)

15 In the twin theatre at the County Hospital there are gutters with open drains in the operating rooms, a design feature which carries a potential risk of infection which should be discussed with the microbiologists. No modern operating rooms contain this feature.

16 Use of the Diathermy Indifferent Electrode

A procedure for checking the placement of the indifferent electrode and the condition of the skin surface after removal should be introduced with a formal method of recording findings. With the current type of plate in use the manufacturer's recommended record of use should be adopted together with their recommended cleaning procedure. Unless these manufacturer's safety recommendations are complied with, injury to patients can still occur despite their intrinsically safer solid state technology. (Codes of Practice NATN Ch 24 6.1)

17 Draping of Patients

The practices observed for draping patients were both variable and casual and contamination of drapes was common.

18 Sigmoidoscopies

Sigmoidoscopies were performed in the anaesthetic room where venopuncture and epidural procedures are also carried out routinely. The potential for cross infection between these procedures should

preclude this practice.

19 Recovery Rooms

It is surprising to us that a patient who has had an operation of less than 30 minutes duration does not have their pulse and blood pressure checked and recorded in the recovery room. Indeed there was no evidence of regular airway monitoring and supervision in the recovery areas and no system of clearly defining and reacting to respiratory and cardiac danger signs in the immediate postoperative recovery period. There was no formal recording of nursing care in the recovery room and no standard practice for recording patient's vital signs during the recovery phase. (Codes of Practice NATN Ch 18 9.1 to 9.4)

20 Monitoring during General Anaesthesia

We take the view that there should be a blood pressure cuff and an ECG monitor applied to every patient under general anaesthesia and there should be some device within the breathing system to ensure that ventilation is adequate. These are the minimum acceptable levels of instrumental monitoring for all patients. (Mortality Associated with Anaesthesia: Association of Anaesthetists of Great Britain and Ireland, page 48)

21 An alternative method should be sought to present glass cartidges of local anaesthetic to the sterile field. We observed these being left soaking in spirit-based disinfectant. There is a known danger that if a hairline crack is present in the cartridge, spirit can enter the injection fluid and cause tissue damage.

PART C

1 Main Points Arising from Discussions of the Administrative Support to Surgical Services

We noted that;

- neither the District Administrator nor the Unit Administrator have in the past had their offices on the County Hospital site and this introduces some remoteness between the administrative support and the major point of care delivery;

- there is no administrative member of the existing Theatre Users Committee although a representative may be invited to attend;

- although the district has a proposal submitted to the Regional Capital Programme with an estimated cost of £10m, and a series of options for upgrading theatres on the County Hospital site (for which £250,000 has been earmarked in 1984/5) there is, as yet, no control plan for the County Hospital or any of the acute hospital sites;

- the district has no well formulated way of preparing rational proposals to which the medical staff respond corporately. The consequence is that planning decisions which have medical staff agreement are slow and therefore often late in developing;

- the district has been involved in a number of studies where additional management information has been produced and reviewed, for example, the comparative study of 15 rural districts and the 'Piloting Korner' exercise. This experience should be utilised where possible to develop administrative systems to inform and support clinical staff regarding their activity and resource use, and to monitor the implementation of agreed plans (see section 3 of this report).

2 Main Points Arising from Discussions concerning the Department of Anaesthetics

We noted that;

- the organisation within the department is fairly informal and there are no formal meetings of a Division of Anaesthetics;

- there is no policy for standardisation of equipment purchased for the different operating rooms in the district;

- there is some spare capacity within the staffing levels to accommodate additional operating sessions and apparently locum cover for consultant anaesthetists is available from the Region;

- the admission policy to ICU maintains a very low average daily bed occupancy of 2.0 beds;

- currently five anaesthetic sessions per week cover this very low occupancy. This seems to us an extravagant use of expensive anaesthetic resources;

- policies for nurse management in the ICU were also unclear;

- the Faculty of Anaesthetists' visitation in 1982 recognised three areas to be in need of attention:

  (a) there was insufficient ICU teaching,

  (b) pre and post-operative visits to patients needed proper organisation and full participation by senior anaesthetic medical staff,

  (c) the recovery area in the Gynaecology Theatre was considered to be unacceptable.

  We doubt if these problems have been completely addressed;

- the programmed training of junior staff, including two tutorials per week and sufficient finance for attendance at external courses, appeared to be adequate. We observed however, that junior staff regularly missed tutorials to cover operating sessions. A consultant should accept the duty of ensuring that this does not occur except in exceptional circumstances;

- these aspects of the anaesthetics department have no direct bearing upon the existence of the waiting list for general surgery, but the potential contribution of the anaesthetists to the Surgical Policy Committee concerned with the standards, practices and full use of available resources is a subject upon which we commented separately (section 5.2).

3 Main Points Arising from Discussions concerning Theatre Nurse Management

We noted that;

- there are a number of factors which disrupt planning the workload of the theatres, such as
  (a) theatre lists arriving in the theatre at very short notice,
  (b) theatre lists being changed at short notice,
  (c) no joint planning of the workload (which in our view is essential),
  (d) no notification of periods of consultant absence,
  (e) no routine preoperative visit to the patient by the anaesthetists to establish fitness for surgery;

- efficient deployment of theatre nurse staff is made difficult by the number of sites on which surgical procedures are carried out. Adequate cover for different theatre sessions, for example at the Victoria Eye Hospital, involves staff transfers from the County Hospital twin theatres;

- these deployment difficulties are enhanced by the number of part-time nursing staff employed since their working hours are often less flexible than full-time staff;

- partly as a result of these deployment difficulties, we observed ODA staff monitoring patients' recovery, a task for which they have minimal formal training;

- several of the concerns expressed in the ENB report on their visit to Hereford have not brought about prompt corrective action;

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- there have been some disparate views concerning the appropriate role of the theatre nursing superintendent. The previous post holder, Mrs Newman, clearly had the support of many of the medical staff and was constantly available to work in the theatres. As the nurse manager responsible for nursing standards in the theatres however, many of the points identified in section B of this report must reflect upon the practices she accepted while in post. Constant availability in theatre may also have limited her potential contribution in addressing the pressing problems of nurse training and deployment which we observed. We have accordingly discussed with nursing and other senior staff the sequence of re-filling this post and have drafted an advertisement designed to recruit appropriate candidates (Appendix 6);

- many of the difficulties being experienced in coordinating theatre activity in order to create high standards of care and patient throughput could be improved by better personal communications between nursing staff, managers and clinicians, and also by more standardised systems for documenting and transferring information between staff groups and locations involved with surgical services.

4 Main Comments from General Practitioners

From the eleven general practitioners who contacted us the following main points were noted:

- a widespread concern about the length of time waited by patients for outpatient and inpatient treatment. In particular GPs were most concerned about the waiting time for a routine outpatient appointment;

- concern that the consultant general surgeons did not read referral letters and therefore could not classify patients awaiting consultation according to their urgency;

- concern for patients with some conditions which the GPs could equally as well identify as the consultant, for example inguinal hernias. The six months wait for an outpatient appointment

merely added to the patient's subsequent wait for admission and treatment;

- GPs would generally welcome earlier discharge of surgical patients both from outpatient and inpatient care particularly when the GPs had access to good support facilities. This would free hospital-based specialist resources for more new patients to be seen;

- open access by GPs to barium enemas and sigmoidoscopy would aid a group of patients who are potentially at risk whilst waiting for routine surgical outpatient appointments;

- regular information about waiting lists and times would help GPs to make more efficient use of the surgical services.

5 Main Points Arising from Discussions concerned with Other Surgical Specialties in the District:

We noted that;

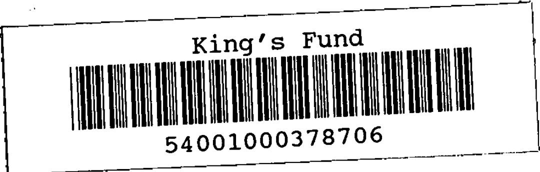
- currently there is no separate provision for beds for children receiving ENT surgery at the General Hospital. Children are treated on wards with adults and this is widely held to be an unacceptable practice, and criticised by the DHSS;

- the ophthalmology beds and theatre at the Victoria Eye Hospital are not used to full capacity. The suggestion was made that the ophthalmology specialty must retain all the hospital bed complement in order to retain recognition for its junior medical staff posts. In other districts we have known the 'normal' bed requirement to be waived where the department can demonstrate an appropriate throughput of patients;

- several representations were made by the consultant gynaecologists that the current proximity of gynaecology and obstetric facilities at the County Hospital should be maintained if at all possible. As described elsewhere, this is not a view we accept;

- from several sources the suggestion arose that if extra operating sessions could be identified and funded, these should be made available to the orthopaedic surgeons as a priority. However, the general surgeons would also welcome extra lists and we believe that the Health Authority should see that the extra lists - which could now be staffed from existing resources - are used by whichever source they consider has the higher priority.

- physicians have no readily available facility for performing endoscopies. In our view, the existing Gynaecology Theatre could become a multi-user Endoscopy Suite in due course.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