# Summary of the 1992/93 Report

(Published November 1995)

Contents

## Sample group

The detailed sample for the 1992/93 Report was deaths of patients aged between 6 and 70 years.

## Recommendations

- NCEPOD has again identified a substantial shortfall in critical care services. Any hospital admitting emergency patients, and hospitals admitting complex elective patients, must have adequate intensive care and/or high dependency unit facilities at all times.
- Trainees with less than three years' training in the speciality should not anaesthetise or operate without appropriate supervision.
- Practitioners must recognise their own limitations and not hesitate to consult a more appropriate colleague when managing conditions outside their immediate expertise.
- The skills of the surgeon and anaesthetist should always be appropriate for the physiological and pathological status of the patient.
- Surgeons operating laparoscopically should not hesitate to convert to an open approach when necessary.
- Appropriately trained staff must accompany all patients with life-threatening conditions during transfer between and within hospitals.
- The medical profession needs to develop and enforce standards of practice for the management of many common acute conditions (e.g. head injuries, aortic aneurysm, colorectal cancer, gastrointestinal bleeding).
- There is an urgent need to improve the quality of medical notes. There was found to be considerable variation in quality among those operation notes included with surgical questionnaires, particularly between specialties. Overall there is a clear need for an improvement in keeping operation records and The Royal College of Surgeons' guidelines and recommendations need to be re-emphasised.
- Managers need to improve the services provided by medical records departments so that notes are available when required.
- The number of postmortems performed remains too low and poor communications persist in some cases between surgeons and pathologists. Whilst the overall quality of postmortems performed is generally satisfactory it would be improved by wider observance of the Royal College of Pathologists' "Guidelines for Postmortem Reports".

## Key points in anaesthesia

The advisors and coordinators in anaesthesia identified areas for which **standards of practice** (the level of modern good practice to which all clinicians aspire) could be written:

- visiting and assessment of patients before operation
- the need for experienced staff for very sick patients
- the availability of trained non-medical staff to help the anaesthetist
- the use of basic monitoring instruments throughout anaesthesia
- the provision of a fully staffed and equipped recovery room
- the use of pulse oximeters in recovery rooms

**Protocols** (locally derived plans to achieve a standard) could be written by individual hospital teams about:

- prophylaxis against deep vein thrombosis and pulmonary embolism
- transfer of sick patients from one hospital to another
- referral of sick patients to more senior staff
- essential laboratory tests and investigations before operation
- retention of staff records and duty rosters
- out-of-hours operating

## Key points in surgery

Seventy-three per cent of the initial admissions to hospital were either urgent or emergencies. Emergency or urgent operations (using NCEPOD definitions) preceded 61% of the deaths. Sixteen per cent of the operations were performed on a Saturday or Sunday, and a further 20% were performed between 18.01hrs and 07.59hrs on a weekday (NCEPOD's current definition of "out-of-hours"). Hospital surgical and management teams need to ensure that adequate provision is made to deal with emergencies during the working day and at the weekends. Sixty-three per cent of all of the operations were performed by consultant surgeons or gynaecologists.

## Key points in individual surgical specialties

### Cardiothoracic surgery

There was effective referral of the workload into specialist centres and a high level of consultant involvement.

### Colorectal surgery

The detection of anastomotic leakage is difficult and sometimes delayed and diagnostic proctograms may be helpful. Rare colorectal conditions should be referred to a surgeon with the appropriate experience. There should be serious scrutiny of policies in those hospitals which still fail to provide emergency theatres on a 24-hour basis.

### Gynaecology

Careful thought is required when selecting cases for day surgery. Gynaecologists who are not trained in gastrointestinal surgery should involve a gastrointestinal surgeon when a bowel repair/resection may be required.

### Neurosurgery

Eighty-nine per cent of the patients who died were emergency admissions. All units receiving patients with multiple injuries, including head injuries, must have access to CT scanning and a radiological and neurosurgical consultation/opinion.

### Orthopaedic surgery

Senior orthopaedic surgeons were frequently involved in the management of patients. The proper use of operating theatre trauma lists and the availability of appropriately experienced staff to utilise these lists is good practice and must be encouraged. The use of venous thromboembolic prophy-laxis in orthopaedic surgery is an unresolved problem.

### Otorhinolaryngological surgery

Adequate local competence and facilities should govern whether or not radical surgery, in particular for head and neck malignancy, is performed in a given situation.

### Urology

Myocardial infarction, sepsis, haemorrhage and venous thromboembolism remain the major specific postoperative complications leading to death in urology. Centralisation and subspecialism are occurring within urological practice.

## Vascular surgery

Ruptured abdominal aortic aneurysms continue to be an important cause of death and contribute towards a heavy "out-of-hours" workload for surgeons "on call" for vascular surgery. Vascular surgery imposes a high demand on critical care services.

## Key points in pathology

The number of postmortem examinations performed remains too low, and poor communication persists in some cases between surgeons and pathologists. Contacts between the Royal College of Pathologists and the Coroners' Society of England and Wales should be developed to address issues of common interest. A concise, jargon-free explanation of the principal findings (clinico-pathological correlation) should be a part of every postmortem report.