The Perfect Surgical Theatre Day

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AIM

Utilisation of the CEPOD operating list by identifying preventable unanticipated events along the journey of the emergency surgical patient.

METHOD

A multidisciplinary team was put together to map the patient's process and carry out a standardised prospective root cause analysis of factors leading to underutilisation of the CEPOD operating theatre and delays in the list. Key areas of focus included:

Patient assessment

Time of decision made to operate and time of operation as well as time planned for the procedure

Correct completion of appropriate proformas and pathway protocols

Appropriate staffing

According to NCEPOD publications Peri-Operative Care[1] and Who Operates When[2].

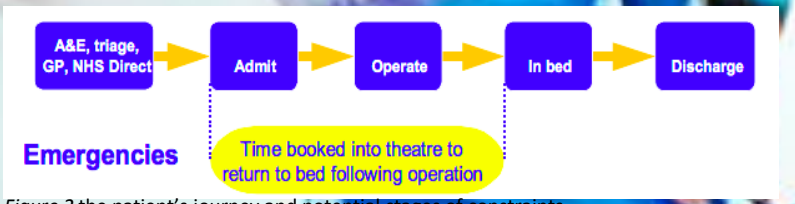
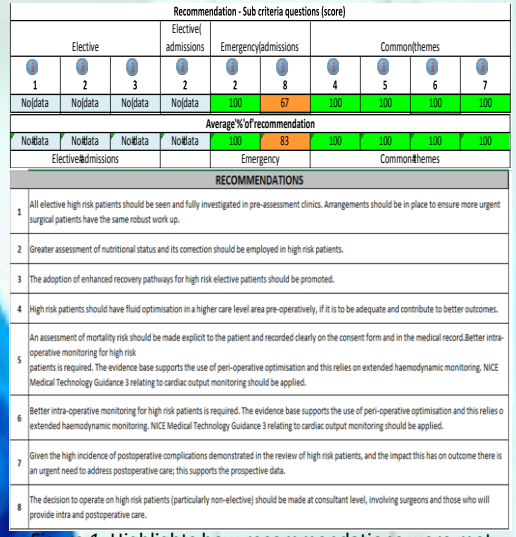


Figure 2 the patient's journey and potential stages of constraints.



Recommendation - Sub criteria questions (score)

Elective			Elective admissions	Emergency admissions		Common themes			
1	2	3	2	2	8	4	5	6	7
No data	No data	No data	No data	100	67	100	100	100	100

Average % of recommendation

No data	No data	No data	No data	100	83	100	100	100	100
Elective admissions				Emergency		Common themes			

	RECOMMENDATIONS
1	All elective high risk patients should be seen and fully investigated in pre-assessment clinics. Arrangements should be in place to ensure more urgent surgical patients have the same robust work up.
2	Greater assessment of nutritional status and its correction should be employed in high risk patients.
3	The adoption of enhanced recovery pathways for high risk elective patients should be promoted.
4	High risk patients should have fluid optimisation in a higher care level area pre-operatively, if it is to be adequate and contribute to better outcomes.
5	An assessment of mortality risk should be made explicit to the patient and recorded clearly on the consent form and in the medical record.Better intra-operative monitoring for high risk patients is required. The evidence base supports the use of peri-operative optimisation and this relies on extended haemodynamic monitoring. NICE Medical Technology Guidance 3 relating to cardiac output monitoring should be applied.
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7	Given the high incidence of postoperative complications demonstrated in the review of high risk patients, and the impact this has on outcome there is an urgent need to address postoperative care; this supports the prospective data.
8	The decision to operate on high risk patients (particularly non-elective) should be made at consultant level, involving surgeons and those who will provide intra and postoperative care.

Figure 1: Highlights how recommendations were met according to the Peri-Operative Care Audit toolkit.

OUTCOME/RESULTS

31% of patients on the CEPOD operating list did not achieve the clinically agreed time to theatre. In 5% of the delayed cases resulted in patients being sicker at the point of definitive care leading to longer recovery time and postoperative complications.

The average start time was 56 minutes later than planned and average overrunning of time planned for the procedure was found to be 27minutes.

Using the NCEPOD Perioperative Audit Toolkit as shown in *Figure 1* it was identified that *Recommendation 8* (The decision to operate on high risk patients should be made at consultant level, involving surgeons and those who will provide intra and postoperative care.) would be an area for improvement. A patient mapping process was used as a diagnostic tool to identify the constraints in the patient's journey for surgery.

CONCLUSION

Emergency surgical patients are a unselected group of patients with different possible surgical diagnosis ranging from stable to potentially life threatening conditions. These patients have the potential to deteriorate rapidly. Hence, it is imperative to optimise every step of their care and utilise resources appropriately.

REFERENCES

Knowing the Risk A review of the peri-operative care of surgical patients A report by the National Confidential Enquiry into Patient Outcome and Death (2011)

"Who Operates When II" (The 2003 Report of the National Confidential Enquiry into Perioperative Deaths. NCEPOD. London, 2003).

https://www.ncepod.org.uk/2011poctoolkit.html