CURRENT CHALLENGES OF PATIENT PREPARATION
(Pre operative Assessment)

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ENHANCED RECOVERY

Delivering enhanced recovery
Helping patients to get better sooner after surgery
Enhanced Recovery
www.dh.gov.uk/enhancedrecovery

• It is a novel approach to elective surgery based on the following principles:
  – patients are in the optimal condition for treatment,
  – patients have different care during their operation, and
  – patients experience optimal post-operative rehabilitation

• Enhanced Recovery Programmes (ERPs) may be referred to as Rapid, Accelerated Recovery or Fast Track surgery and originally pioneered in Denmark

• They must involve the whole health community

• With the compelling clinical evidence base they should be best practice elective care pathways
Enhanced recovery elements

Referral from Primary Care
- Optimise pre-operative haemoglobin levels
- Manage pre-existing comorbidities e.g. diabetes

Pre-Operative
- Minimally invasive surgery
- Transverse incisions (abdominal)
- No NG tube (bowel surgery)
- Regional or LA +/- sedation
- Epidural use (inc thoracic)
- Optimised fluid management
- Individualised goal directed fluid therapy

Admission
- Minimise starvation
- No/reduced oral bowel preparation (bowel surgery)
- Optimise hydration
- CHO loading
- No wound drains
- No NG (bowel surgery)
- Catheters removed early
- Optimal fluid management
- No systemic opiate-based analgesia
- Topically

Intra-Operative
- Rapid hydration & nourishment
- Appropriate IV therapy
- No systemic opiate-based analgesia
- No systemic opiate-based analgesia

Post-Operative
- Therapy support (stoma, physio, OT)
- 24hr telephone follow up

Follow Up
- Dx when criteria met

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Who is it for?

- Would you really create a service just for ‘enhanced recovery’ patients?
- Shouldn’t all elective patients benefit from pre-operative preparation?
- Shouldn’t all inpatient surgery follow an ‘enhanced recovery’ pathway?
Quality care

- personalised
- quality assured
- efficient
- effective
- appropriate time
- minimal cancellations
- minimal complications
- shortest possible time away from home
Patient preparation

• begins with patient presentation in primary care
• history, examination +/- investigations
• GP referral
• informed decision-making begins
• fit, optimise co-morbidities
• willing
• able
• expert opinion in OPD

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Patient preparation - safety

- fit for surgery / anaesthesia?
- pre-operative assessment (POA)
- current and past health status
- identify factors that increase patient risk
- identify factors that may affect effective surgery / anaesthesia
- appropriate investigations
- optimise or refer for specialist advice
- inter-professional teamwork
- Pharmacist: VTE prophylaxis, Warfarin, Aspirin/Clopidogrel, DM

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Public Health trends
Obesity

- BMI = \text{weight (kg)} \div \text{height (m)}^2
- <20 underweight
- 20-24 healthy
- 25-29 overweight
- 30-39 obese
- 40 – 45 very obese
- >45 super obese
Mortality due to Obesity

• Risk increases with lack of cardio-respiratory fitness

• Mortality if BMI >30 is 50% higher than person with BMI 20-25

• Increase mortality for those who have long term obesity
To show the Body Mass Index of patients 2010

11043, 57%
8415, 43%

BMI >30
BMI <31
Smoking
18% patients smoke

- Reduces oxygen levels
- 43% increase in developing osteoporosis
- 13% increase risk of fractures
- Delayed wound healing
- Wound infections
- Increased length of hospital stay
DEPARTMENT OF HEALTH
REQUIREMENTS

PURPOSE –
TO IMPROVE PATIENT SAFETY

• MRSA
Multi Resistant Staphlococcus Aureus

• vCJD
Varient Creutzfeldt Jacob Disease

• VTE ra
Venous Thrombo Embolism risk assessment

• PROMs
Patient Reported Outcome Measures
Patient preparation

- planned admission – environment/level of post-op care
- appropriate anaesthesia
- negotiated admission date
- expected discharge date / criteria
- special needs identified and communicated
- prosthetics
- minimal cancellations on day of surgery
Joint School

- MSK patients
- multi professional
- patient and sponsor attend
- advice
- reassurance
- reinforce the pathway

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Discharge planning

Aim
• appropriate, timely discharge to safe environment

Objectives
• identify patient support prior to admission
• patient to make arrangements to stop / start current support services
• identify new support required on discharge
• Social Services request form completed at POA
• form faxed to Social Services on admission
• minimal delays due to social reasons

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Role of the Anaesthetist
The role of the ‘Anaesthetist’ in Pre-operative Preparation - Patients

- Review of results from nurse assessment, recommend further actions
- To inform and discuss interventions such as epidural / spinal
- To identify need for HDU / CCU and discuss with patient and relatives / carers
- Patient discussion – need for surgery and anaesthetic v life expectancy – **informed decision making**
- Conversation about NOT having surgery and communicating decision path back to surgeons / GP
- Cardio Pulmonary Exercise testing /other advanced testing

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To show the number of patients attending Patient Preparation per annum

22798 patients in 2010
Patient cancellations on day of surgery

• Did not arrive
• Cancelled within 24 hours of procedure
• Unfit on the day – Chest infection, urinary infections
• Pregnant
• Patient ate / drank / took medication
Finally…..

- accurate POA is essential to providing effective admission and good patient outcomes

- inter professional teamwork is key

- primary and secondary care involvement is required

- patient must be fit, willing and able to proceed at point of referral

- overall objective – to ensure this gold standard of care becomes the norm for every patient admitted for elective care
For more information

- www.pre-op.org
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