



PREOPERATIVE ASSOCIATION SUMMER NEWSLETTER

July 2008

MESSAGE FROM THE CHAIR



Dr David Earl
Chair, Preoperative Association

As the warm weather hints at arrival in the UK and summer threatens to appear, our thoughts are already on the autumn/winter. Firstly, the full implementation of the 18 weeks program in England will be upon us, and the role of preoperative assessment has become a vital component in delivering the target. It is incredible to recall what the situation was like 5-10 years ago, and it is heartening that the development of structured

preoperative assessment has led to such radical improvements – not just in speed of treatment, but also in terms of quality of patient experience and safety.

This brings me on to the second important issue at the end of the year. As you may be aware, preparations are in full swing for the Preoperative Association annual conference, entitled “A Risky Business”, which is to be held on Thursday 6th November 2008 at the Royal Court Hotel, Coventry. Full details of how to register are on the website, together with a provisional program. We are delighted to welcome Dr David Hepner to the conference this year. Dr Hepner is currently chair of SPAQI, our North-American “sister” organisation, and we are very much looking to hearing his views.

With regard to other content at the conference, we have tried

to select topics which will provide interest to the wide array of professions in our association – nurses, anaesthetists, surgeons, pharmacists etc. The venue is larger than last year’s with a number of breakout rooms available, which enable a much wider variety of subject matter to be covered. We have paid particular interest to feedback from previous years’ events, so thank you to all those attendees for their comments. The Preoperative Association exists only for its members, and I would strongly encourage all members to contact me via the website with any comments – either about the conference itself or about what direction they feel the POA generally should follow.

I look forward to hearing from you, and seeing you in November after a long, hot summer.....

Dave Earl

Special points of interest:

- CONFERENCE 2008
- CALL FOR PAPERS
- FOCUS ON PRE-OP ASSESSMENT AND POLY-CLINICS
- FREQUENTLY ASKED QUESTIONS (FAQ’S)
- LINKS

A Letter from the Editor

Dear colleagues,

Welcome to the summer edition of your newsletter. Steering group members of the Preoperative Association are once again preparing for this year’s conference and we have further information for you in this edition.

If you would like to contribute an article / interest piece / news item or letter please send it to the editors via the pre-operative association website. (www.pre-op.org)



PREOPERATIVE ASSOCIATION ANNUAL CONFERENCE



THE ROYAL COURT HOTEL

For full details on how to book your place please visit

www.pre-op.org

6th November 2008

at the

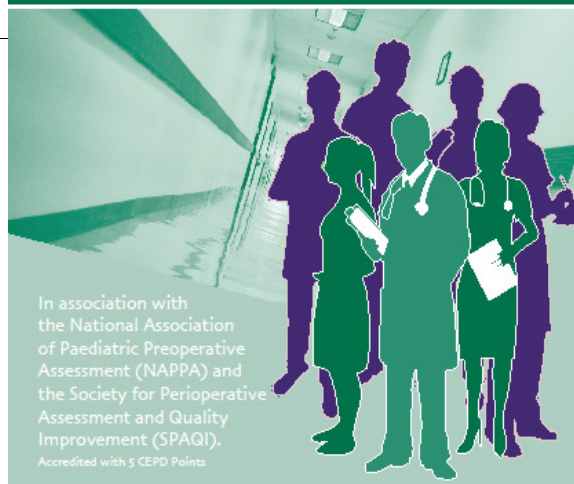
Royal Court Hotel
Coventry

Register now!

Reduced rates for fully paid up members of the Preoperative Association.

The Preoperative Association 2008 National Conference

6th November 2008 Royal Court Hotel, Coventry



"A risky business"- Reducing the risks associated with anaesthesia and surgery.

Open to all doctors, nurses and other health professionals involved in preoperative assessment in both NHS and independent sectors. Abstracts for presentations or posters to be submitted by August 1st.

AN OPPORTUNITY FOR YOU TO SHOWCASE YOUR WORK!

CALL FOR PAPERS

Deadlines:
1st August (Papers)

1st September (posters)

The Preoperative Association would like to make a call for papers to be presented at the fourth National Conference. **'A Risky Business'**

Themes for papers:

Clinical and Technical

(For example but this is not exclusive)

- * Revised Cardiac Risk Assessment
- * Drug Eluting Stents- Clopidogrel
- * thromboprophylaxis
- * CPX testing
- * Cardiology support for Pre-op
- * risk
- * Infection control



- * **Technology** supporting Pre-op

Organisational and service development

(For example but this is not exclusive)

- * **Training** to support as sessors in preoperative assessment
- **Developing** a blend of models to increase the capacity of your pre-op service
- * **Enhancing** patient safety and outcomes through pre-op assessment



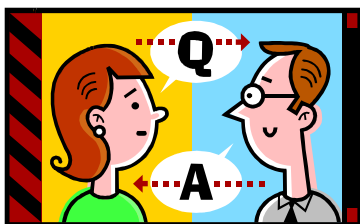
Policy

(For example but this is not exclusive)

- * Multi sector approaches to delivering pre-operative assessment
- * Commissioning pathways including pre-op assessment
- * CATS/ICATS
- * The role of pre-op in polyclinics

For further information please visit our website www.pre-op.org or email us at info@pre-op.org

SOMETHING TO SHARE ?



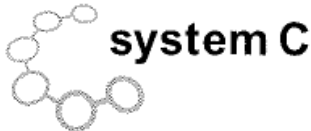
Where else will you find 200+ inter professionals networking and team building with the common goal of providing best patient care through Pre operative Assessment? We are fortunate to have many exhibitors who have confirmed their

attendance at the Preoperative Association conference 2008. Perhaps your interest is in VTE prophylaxis, or Cardiopulmonary testing, or you may want to know more about the 18-week developments, and if you fancy looking after yourself you may decide to visit the Yakult stand - free

samples included! Do you know of anyone who would like to share their products with a wider audience? If so, please contact Jane Jackson at the preoperative association with details. (www.pre-op.org)

Summer Newsletter

A cross section of the Industries sponsoring The 2008 Preoperative Annual Conference



FREQUENTLY ASKED QUESTIONS by LEE WADSWORTH

SMOKING CESSATION

We have many enquiries at the association regarding smoking cessation prior to surgery. Some members report that they do not ask patients to stop smoking if the surgery is taking place citing that the patient may well get respiratory symptoms after stopping and therefore have poorer respiratory function for their surgery. Fortunately, a systematic review (type 1 evidence) from 2006



provides a strong evidence-base for getting patients to stop. This study concluded that " Longer periods of smoking cessation appear to be more effective in reducing the incidence/risk of postoperative complications; there was no increased risk of post-operative complications from short-term cessation. Pre-op Assessors should refer patients to the primary health care team or directly

to smoking cessation services. Here patients can receive the appropriate support and or medication to assist with their cessation.

References

Theodom A. Cropley M (2006) Effects of smoking cessation on the incidence and risk of intraoperative and postoperative complications in adult smokers :a systematic review. Available at <http://tc.bmj.com/cgi/content/abstract/15/5/352>

Replies are the individual views and opinions of members of the Preoperative Association steering group and whenever possible supported by the best available evidence, however if you have an alternative view or comment to enhance the debate please contact us at info@pre-op.org If you have a question you would like to ask via the newsletter and website then please contact us at the same address that's info@pre-op.org

Links to more news and Information (Members viewing on website please click on the logo)

SPAQI
(Society for
Perioperative
Assessment and
Quality)



Preoperative
Association

"members only" area:

The Preoperative
Association
www.pre-op.org



to the
Preoperative
Assessment
Clinic

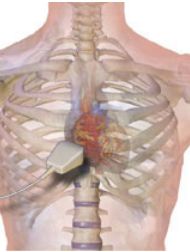


When should I request a Pre-op Echocardiogram?

Echocardiogram



An echocardiogram uses sound waves to produce an image of the heart.



IT IS IMPORTANT TO REASSURE PRACTITIONERS THAT MOST PATIENTS DO NOT HAVE SERIOUS HEART VALVE LESIONS AND MANY MURMURS TURN OUT TO BE "FLOW MURMURS" AND THESE PATIENTS DO NOT HAVE STRUCTURAL ABNORMALITIES OF THE HEART VALVES.

An echocardiogram should be requested when a patient is found to have a heart murmur at pre-op assessment. The risks of an undiagnosed heart murmur were highlighted in the NCEPOD report 2001 concerning undiagnosed aortic stenosis. This stated:

In view of the National Confidential Enquiry into Peri-Operative Deaths some patients may require pre-op echocardiogram.

- An asymptomatic murmur may indicate significant cardiac disease.

- Patients with a large aortic valve gradient or small aortic valve area, particularly in association with a reduced ejection fraction, have an indication for invasive monitoring, ICU/HDU care and excellent post-operative pain relief.

- Whenever possible the anaesthetist of a patient Aortic Stenosis should obtain a pre-op echo of the aortic valve.

Reassuringly most patients found to have asymptomatic murmurs at pre-operative assessment usually do not have this lesion, however we can not be 100% sure without an echocardiogram. With more and more pre-operative assessors being trained in cardiac auscultation staff must be clear when this investigation should be requested. Prior to requesting the echo an ECG should be recorded.

The person who requests the echocardiogram varies; in some organisations it must be a Doctor, whereas in other services Nurses are able to request within protocol. So when should we request?

- An undiagnosed heart murmur found at Pre-operative assessment.

- A patient with an established murmur who has not had an echocardiogram within the past 12 months.

- On the advice of Anesthetist after consulting with him regarding a patient with a heart murmur or cardiac condition

- Always be more concerned if the heart murmur is associated with reduced exercise tolerance, exercise-induced angina, major surgery or an ECG demonstrating left ventricular hypertrophy.

It is important to reassure practitioners that most patients do not have serious heart valve lesions and many murmurs turn out to be "Flow murmurs" and these patients do not structural abnormalities of the heart valves. If a patient states they have a heart murmur and they have already had a echo in the past which was normal and you are able to view this report, this should not need to be repeated.

References

1. **National CEPOD.** Changing the way we operate. The 2001 Report of the National Confidential Enquiry into Perioperative Deaths page 40.



"He's survived the operation. Now he's sleeping peacefully!"

Summer Newsletter

FOCUS ON:

Can pre-operative Assessment Influence the Delivery of Care Outside Hospitals?

Much activity is currently taking place around commissioning future state healthcare services. The landscape of healthcare is changing dramatically with a clear focus on Primary Care Medical Services, a major shift from the traditional acute hospital providing care to patients.

On a recent visit to Berlin where healthcare delivery is focused upon the management of patients presenting with an illness promptly, efficiently and effectively in the most appropriate setting, I was able to witness first hand how patients are currently choosing to visit the polyclinic where they can receive a consultation with a GP, have diagnostic tests performed and reviewed by a specialist within the same building in the same day.

GP services are supported by specialist services. No service where a patient needs to lie down is offered out of the polyclinic. Those requiring this type of care are referred in the normal way to the local hospital provider. However all the planning for a hospital stay is carried out within the polyclinic. All staff working within the polyclinic receives training and ongoing education within the centre

and there are opportunities, which support the close networking of the GPs, specialists and practitioners.

The centre was extremely calming. No ringing phones at reception points or practitioner stations as they are supported by an off site call centre operation. This clearly reduces the stress felt by staff when they are faced with patients in front of them and phone calls, which need to be answered.

In light of Sir Ara Darzi's interim report where it is suggested that we will start to see polyclinics in the UK as early as this year, pre-operative assessment services must ensure their service is provided at the most appropriate point in the patient pathway and this may mean a shift towards commencing pre-operative assessment from primary care settings.

Over the last few years, pre-operative assessment services have been developing to support the delivery of shorter waiting times and in turn this means that our services must integrate fully with those offering care outside hospitals. It is imperative that as soon as

they are referred they are directed towards a high performance clinical assessment service, which ensures they receive diagnostic tests in a timely manner and also ensures the provision of information to support their surgical journey. Furthermore it is an opportunity for pre-operative assessment to support the wellness agenda.

The impact of high performing services on organisations means that the efficiency of healthcare delivery is increased through the preparation of patients prior to their referral for treatment rather than looking for waste within the system.

These new policy initiatives may sound like all talk but with a little effort what has been described above can be put into action here in the UK. Remember, patients are asking to receive care in an environment, which is convenient for them and one, which they themselves have chosen.

Pam Parry
Perigon – Consulting from
System C



IN LIGHT OF SIR
ARA DARZI'S
INTERIM REPORT
WHERE IT IS
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THE PREOPERATIVE ASSOCIATION

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The Preoperative Association is a Society created to provide a forum for tabling matters of mutual interest to all those involved in the field of preoperative assessment. It further aims to provide you with contacts and links within the field of preoperative assessment, focussing on new developments, current practices and tackling burning issues which are of current interest.

**Preoperative
The Association**

THE PREOPERATIVE ASSOCIATION ANNUAL CONFERENCE

“A RISKY BUSINESS”
ROYAL COURT HOTEL, COVENTRY
06 NOVEMBER 2008



Accredited with 5 CEPD Points

PROVISIONAL PROGRAM

Main Auditorium

08:30-09:30	Registration
09:30-09:40	Welcome
09:40-10:20	Keynote Speaker - Joan Russell, Head of Anaesthesia/Surgery, National Patient Safety Agency (NPSA).
10:20-11:00	Cardiovascular risk – the role of pre-assessment Speaker - tbc
11:00-11:30	Tea
11:30-11:55	The obese/bariatric patient – Preassessment from the nursing viewpoint – J. Bramhall, Heart of England NHS Trust
11:55-12:20	Anaesthesia Risk in the Bariatric patient – Dr M Bieker, Heart of England NHS Trust
12:20 -13:00	Proactive care of older people undergoing surgery (POPS) – Dr Jugdeep Dhesi, Department of Health & Ageing, Guys & St Thomas' Hospital Foundation Trust
13:00-14:00	Lunch
14:00-14:30	How to reduce risk in the diabetic patient – Louise Hilton, Senior Nurse (Diabetes), Bolton
14:30-15:30	Infection Control issues in preassessment – Dr Peter Jenks, Director of Infection Prevention and Control, Plymouth
15:30-16:00	Tea
16:00-16:20	The new AAGBI Preassessment Guidelines – Dr J Carlisle, Consultant Anaesthetist, Torbay District General Hospital, Devon
16:20-17:00	Keynote Speaker: Issues in Perioperative Anticoagulation - Dr David Hepner, Chair of SPAQI.
17:00-17:10	Close

Breakout Room 1

NAPPA – National Association of Paediatric Preoperative Assessment

Breakout Room 2

Free Papers

11:30 – 13:00	CPX testing in action
14:00 – 15:30	CPX testing in action

Program correct as of 04/07/2008