GIRFT, RCS and ASGBI

Best practice for Laparoscopic Appendicectomy Documentation

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GIRFT is part of an aligned set of programmes within NHS England

Contents

1. Background and Justification

This guidance has been produced by GIRFT in partnership with the Royal College of Surgeons of England (RCS) and Association of Surgeons of Great Britain (ASGBI). It is aimed to provide advice on various aspects of surgery which should be available and clearly documented in a laparoscopic appendicectomy operation record. The document is not a comprehensive guide to this surgical procedure, however it is hoped that surgeons will find the advice it offers helpful.

This document was developed from the analysis of existing guidance, medical negligence claims notified to NHS Resolution by NHS trusts, feedback from NHS panel firm lawyers and expert witnesses. It has been established that poor operative documentation has made the investigation of incidents leading to claims difficult and has prevented the defence of good clinical practice. This guidance seeks to provide (non-mandatory) recommendations of what would reasonably be expected to be documented to support for both good clinical communication with colleagues and potential review of operations, if operation was reviewed in response to a patient complaint.

It is expected that the recommendations listed would be included within the documentation of patient care and although the majority will be included in the operation notes, the information could be contained elsewhere in the patient record including assessment in A&E, ward round entries, a separate WHO Surgical Safety Checklist and drug charts. It is preferable where possible that the operation record is typed. The documentation where appropriate may be made by other members of the surgical team apart from the operating surgeon. However, it is the operating surgeon's responsibility to ensure that appropriate documentation has occurred. The operating record should accompany the patient into recovery and to the ward.

The guidance includes case vignettes which provide useful context and should be read in parallel with the recommendations.

2. Recommendations for documentation of practice in all patients undergoing laparoscopic appendicectomy

1. The indications for the operation and the evidence both in terms of serological markers, imaging, presenting complaint and clinical examination that has led to the recommendation to perform this operation.
2. Record the time the decision was made to perform surgery and also if surgery was subsequently deferred and the reasons for delay.
3. Documentation of the informed consent process including the risks of not operating should be available. The likelihood of a blood transfusion or the need to proceed to an open procedure, a laparotomy or any other additional procedures as relevant should be recorded along with the associated risks. It should be clearly documented if the patient does not consent to any of these relevant procedures including transfusion.
4. Safety briefing, sign in, time out, and sign out as part of WHO Surgical Safety Checklist[1]. Presence of required surgical equipment for both laparoscopic and open procedures should be confirmed[2].
5. Record names of all surgeons with name/grade of lead surgeon and assistants.
6. Record names and grade of anaesthetist(s) and type(s) of anaesthetic used.
7. Record the date and time of the procedure.
8. Record drugs given pre-operatively and during surgery e.g. antibiotics, local anaesthetic
9. Record the insertion of a urinary catheter if carried out.
10. Record patient position and skin preparation.
11. Describe or draw the location of the incisions made.
12. Record the open or closed technique used to enter the peritoneal cavity with a Hassan or Verres needles and that the pneumoperitoneum was established prior to the laparoscope insertion.
13. Confirm that the laparoscope was inserted into the abdomen under direct vision.
14. Document the insertion of the other ports both in terms of position (left lower quadrant, supra-pubic etc.) and size (5/10/12mm) and that they were inserted under direct vision +/- use of local anaesthetic.
15. Record the level at which the intra-abdominal pressure was set.
16. Record if the patient was placed in the Trendelenburg position with the left side down.
17. Document the findings at the time of surgery, whether the appendix was simple /perforated/necrotic, pelvic/retro-caecal/sub-phrenic/mid-abdomen, the presence of abscess or diffuse peritonitis.
18. If the appendix appeared normal what further actions were carried out to diagnosis the source of the clinical presentation and what was found.

19. Record how the appendix was located and whether it was easily identified.
20. Record whether the appendix was ligated between endo-loops using laparoscopic scissors or stapled.
21. Record whether the appendiceal artery was simply divided by cautery or needed to be divided between clips.
22. Record whether the remainder of the mesoappendix was dissected and whether the base of the caecum was healthy and left intact noting whether the junction of the appendix and caecum was clearly seen.
23. Record the volume of irrigation used for washout.
24. Document whether the appendix was placed in a sterile endoscopic bag for extraction and through which portal or incision it was extracted.
25. Record whether the appendix has been removed whole and whether any residual was left behind.
26. State that the tissue sample was sent to pathology.
27. Record that haemostasis was achieved.
28. Record that the ports were removed under direct vision.
29. Record any intra-operative complications and what action was taken to remedy them including conversion from laparoscopic to open, any additional procedures performed and the rationale for them.
30. Record details of closure including whether fascia needed to be closed and use of drains.
31. Document an estimate of the anticipated blood loss.
32. The post-operative plan including:

a. Antibiotics;
b. Blood tests if required e.g. haemoglobin;
c. The location the patient should be transferred to if they need higher level care e.g. HDU, ITU;
d. Frequency of clinical observations in the post-operative period;
e. If used, when drains should be removed;
f. The need to check pathology results for the specimen sent;
g. VTE thromboprophylaxis (including risk assessment and deviations from local protocol).
h. Post-operative recovery including when the patient should eat and drink;
i. Discharge plans;
j. Removal of sutures where required
k. Any follow up.

33. Any images taken during the procedure should be printed out and attached to the operation record.
34. Signature of the first surgeon alongside their name and grade to confirm the record is complete and accurate.

3. Duty of Candour

It is important that appropriate duty of candour be exercised informing the patient of any events or peri operative complications which could cause harm or compromise their outcome, at the earliest opportunity following detection and as deemed appropriate by the treating team. This should be carried out in accordance with local policy and should include a clear apology, an offer of an appropriate remedy (if possible) and/or support. The communication should detail the short and long-term effects of what has happened, to the patient.[3]

4. Case Vignettes

Case vignette 1

Incomplete removal of appendix

A patient underwent a laparoscopic appendicectomy which was uncomplicated. He returned 18 months post-operatively with further right sided pain. Having been investigated for over one year he was admitted for laparoscopic stump appendicectomy. At surgery the patient was found to have an appendix approximately 12.5cm in length. This was explained as duplicate appendicitis, however there was no evidence for this. The likely explanation was incomplete appendicectomy but surgical records were scant.

A clinical negligence case was brought and admissions had to be made in the absence of a clear documentation to the contrary. The damages have yet to be valued but will be significant.

Message

Documenting operative findings including any stump level left and operative technique, with detailed and clear description is important, not just in potentially defending a later claim, but more importantly in managing ongoing patient care, when post-operative difficulties are suffered.

Case vignette 2

Failure to document intra-operative findings and change in procedure performed

There was a failure to document in the notes that the appendix had not been removed during a laparoscopic appendectomy. The appendix could not be seen due to a large abscess. A washout and drainage of the abscess was performed, which the defence expert advised was reasonable, but the failure to record that the appendix was left in situ was a breach of duty. Unfortunately, the patient continued to deteriorate as the rest of the clinical team were not aware that the source of the infection remained in situ, and therefore when the patient did not improve the appendix was not removed in the days immediately following the initial procedure. If the fact the appendix remained had been clearly documented then the patient could have avoided subsequent multiple operations, including the laparotomy and temporary stoma and so would have led to a reduced hospital stay and a quicker recovery.

The claim settled for £70,000 of damages. The Claimant was left with a large abdominal scar, now avoids contact sports that he previously enjoyed and has become introverted. The Claimant also had a prolonged stay in hospital, which included intensive care with multiple operations and a temporary stoma. Special damages covered past care, massages, private tutors due to missed education and the cost of scar revision surgery costing more than £50,000. Legal Costs are yet to be finalised but are expected to be substantial.

Message

Document if there are any intra-operative complications or unexpected findings and if part of the original planned procedure is not performed and the rationale for this. Ensure that any intra-operative decision making is communicated to the patient and clinical team with an explanation behind the change in procedure performed and document that this was communicated to the patient and any questions have been answered.

Case vignette 3

Delay in surgery with failure to inform patient of the risks related to conservative and surgical management

A patient brought a claim for the allegedly negligent delay in treating appendicitis resulting in perforation of the same and the need for an avoidable laparotomy and bowel resection requiring a temporary stoma. It was also alleged that the patient developed an otherwise avoidable post-op complication of pulmonary embolism and abdominal hernia.

The total damages and legal costs paid were around £100,000.

Message

Conservative treatment was appropriately instigated following the patient's admission. However, the discussion regarding the patient's treatment options (conservative or surgical treatment) and the associated risks and benefits were not documented. Similarly, the rationale for the initial conservative management was not documented despite the complex presentation which included intra-abdominal abscesses. The claim was, therefore, settled as there was no record the patient had been fully informed.

5. Acknowledgements & References

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[1] WHO Surgical safety checklist, http://www.who.int/patientsafety/safesurgery/ss_checklist/en/
[2] National safety standards for invasive procedures, https://improvement.nhs.uk/resources/national-safety-standards-invasive-procedures/
[3] Openness and honesty when things go wrong: the professional duty of candour, https://www.gmc-uk.org/-/media/documents/DoC_guidance_englsih.pdf_61618688.pdf