NHS England

GIRFT GETTING IT RIGHT FIRST TIME

NHS IMPACT Improving Patient Care Together

Rationalising preoperative assessment for patients undergoing procedures involving local anaesthetic

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Supporting theatres, anaesthesia and perioperative medicine services

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

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Scope (patients this guidance is applicable to)

- ✓ **INCLUDES** Patients undergoing procedures requiring local anaesthetic only e.g. a range of minor surgical procedures and operations across several specialties.
- × **EXCLUDES** Patients needing interventional radiology, endoscopy, colonoscopy, sedation, general or regional anaesthesia.
- × **EXCLUDES** Patients undergoing cardiology procedures for specific cardiac conditions, typically involving cardiac stenting, pacemakers, implantable defibrillators or cardiac ablation.
- × **EXCLUDES** Cataract surgery, further guidance on which is available here.

Key principles to rationalise POA for patients undergoing LA only

- ☑ There should be a separate, streamlined process for preoperative assessment of patients undergoing procedures using local anaesthetic only.
- ☑ In this process, each patient should be assessed using a standard screening questionnaire relevant to the procedure and the essential information required by the operator.
- ☑ This screening can take place when patients are listed for surgery (either in their outpatient appointment or remotely afterwards).
- ☑ Completing the questionnaire can be facilitated by any suitably trained healthcare professional, including healthcare assistants, nursing associates, assistant practitioners, and registered healthcare professionals.
- ☑ Clear escalation plans need to be in place as per local policy to enable patients to access pathways relevant to specific conditions as needed.
- ☑ Many procedures under LA can be done outside of a theatre environment. Further advice is available in GIRFT's RPRP guidance.
- ☑ Medications (unless omission required for the procedure) should continue as normal.
- ☑ IPC screening (CPE/MRSSA/MRSA) is generally not required unless patient admitted to high-risk area or has patient related risk factors (see our MRSA guidance) which should be determined by local policy and UK Health Security Agency guidance on Actions to contain carbapenemase-producing Enterobacterales.

What the assessment should cover:

Clinical history and patient needs

- ? Allergies/anaphylaxis history
- ? Previous problems with LA, including immediate family members
- ? Anticoagulation and antiplatelet therapy and the requirement to stop specific to procedure
- ? Significant haematology history – past and present (i.e. sickle cell/factor V Leiden, haemophilia)
- ? Any significant respiratory history which may affect position for procedure (i.e. lying flat/prone)
- ? High body mass index (BMI) and weight which may affect position for procedure or special equipment to carry out (i.e. specially required trolley)
- ? Unstable disease which may affect healing (i.e. diabetes)
- ? Pre-procedure surgical requirement (specific preparation i.e. skin prep)
- ? Patient-specific needs including anxiety/communication/literacy/specific required support

Consent and documentation

- ! Patient consents to an LA being performed
- ! Completion of essential documentation for admission to an LA pathway (often locally determined)
- ! Patient information specific to procedure/operation

Why streamline assessments?

Through work with the Non-medical POA Network, we know there is evidence of patients undergoing local anaesthetic (LA) procedures often being assessed in the same POA clinics as those requiring general or regional anaesthesia. This typically has two downsides:

It uses clinic slots that could be allocated to patients needing more complex assessments. These clinic slots are typically 30 to 45 minutes long and, with potentially 50 or more LA patients being assessed in these clinics each week, this can delay access for patients needing more detailed preoperative assessments, ultimately pushing back their 'to come in' (TCI) dates.

It increases the risk of unnecessary testing for LA patients, given that attending POA clinic puts them in an environment where additional testing is common (due to risks associated with general anaesthesia).

The alternative approach described here resolves this issue by separating and streamlining the assessment process for these patients. It can be delivered by a wide range of staff, provided clear escalation protocols are in place to access local pathways for specific conditions where required, and is already in use at a number of NHS provider sites. Illustration of how this would work in practice is described in the scenario below.

Illustrative patient scenario

A patient has been listed under plastics for removal of a lesion that is thought to be cancer. The lesion is quite large but can be removed under LA. The patient is added to the waiting list where it is highlighted that the patient takes a blood thinning medication which should be stopped as per surgical preference. A healthcare assistant completes a pre-screening questionnaire and identifies that the patient is taking apixaban. They refer to a registered clinician for advice as per local policy for instructions on when to stop the medication.

Additional guidance: the contents of the assessment

Allergies and anaphylaxis

A full list of allergies and anaphylaxis history should be noted in the patient records and alerts used where necessary. This should be cross checked with primary care records.

LA history

Patients should be asked about any history of adverse reactions or identified problems with previous LAs where applicable.

Anticoagulation and antiplatelet medication

All patients should be asked if they are on any of the anticoagulation and antiplatelet medications set in this quick reference table. If there is a requirement to stop any of these medications before the procedure is carried out, this should be communicated to a relevant registered healthcare provider (RHCP) for advice and management or following local guidance. Clear instructions should be given to the patient and a follow up call should be made before the procedure is carried out. Special attention should be made to metered dose boxes and support for patients who need help removing them prior to the time of surgery. As medications have specific protocols, all information given should be in line with local policies.

Haematology history

As with any surgical procedure/operations, bleeding risk should be considered. Specific questioning on any existing haematology disease and bleeding history should be explored in addition to family history relating to haematological disease.

Respiratory history

Patient with existing respiratory problems should be identified specifically if there is a requirement to lay down for the procedure. This includes, but is not exhaustive, to:

- COPD/emphysema
- Requirement of oxygen therapy/non-invasive ventilation (NIV)
- Asthma (remind patients to bring in their inhaler therapies where appropriate)
- Ability to lie flat
- Any other unstable respiratory disease

BMI and weight

BMI should be measured at the time of listing for LA procedures. The healthcare staff should communicate any potential weight related issues to the scheduling teams in case there are requirements for special equipment to perform the procedure.

Unstable co-morbid disease

With any surgery/procedure, there is a risk of infection and wound healing specific to the procedure/surgery being carried out. Unstable disease such as diabetes may increase this risk. Patients should be informed during consent and their most recent bloods reviewed to ascertain this risk, which should be discussed with the listing clinician where applicable.

Likewise, in patients with unstable cardiac disease or chronic angina with frequent episodes, patients should ensure they are informed about routine medication and bringing in specific required medication for the procedure (i.e. GTN spray). Recently increased use of GTN, more than once a month, should trigger a referral to a senior decision maker. Consult a senior decision-maker/refer to local guidance if the patient has an ICD or pacemaker. Further action may be required if diathermy is being used in the procedure — see appendix for an example protocol.

Pre-surgery requirement

The procedure/operation may have specific patient preparation requirement before being carried out. Patients should be given any preparation requirements before coming into hospital. Certain procedures will need some preoperative testing at the time of listing, such as taking of photographs.

Patient specific requirement and patient centred care

Any procedure/operation - even if an LA procedure - will be specific to every patient. Patient centred care core values and addressing concerns should always be included in any assessment in line with localised admission documentation, to include:

- Communication
- Language
- Ethnicity
- Spiritual needs
- Social needs
- Patient specific physical and mental health needs and reasonable adjustments required

- Opportunity for making every contact count (MECC)
- Information specific advice relating to the procedure
- Infection Prevention and Control requirements

Consent

Consent for any procedure, including LA assessment, should be carried out the same way as any other consent. This should include addressing any inability for informed consent.

Documentation

The amount of documentation required for LA procedures versus other surgical procedures will undoubtedly vary so there should be a review of the essential documentation required, which should be a single pathway from listing to discharge. This should include:

- Patient demographics
- Health screening questionnaire and patient centred care needs, including the above considerations
- Opportunity for making every contact count (MECC)

Quick reference tables

The following pages contain quick-reference tables that summarise the contents of the assessment. They also provide an easy reference for antiplatelet and anticoagulation medications. Readers are encouraged to screenshot these and print out locally, should they find this helpful.

Quick reference table: What to cover at preoperative assessment for patients listed for LA

Point to cover	What to do
Allergies / anaphylaxis	List allergies and anaphylaxis history in patient records, alerts, cross check with primary care.
Local-anaesthetic (LA) history	Ask about any history of adverse reactions or problems with previous LAs.
Anticoagulant / antiplatelet drugs	Ask if on anticoagulation or antiplatelet medications, follow local guidance before procedure.
Haematology / bleeding risk	Ask about existing haematology disease and family history, seeking senior guidance if present.
Respiratory history	Identify respiratory problems; assess lying-flat ability, COPD, oxygen therapy, asthma before procedure.
BMI & weight	Measure BMI at listing; notify scheduling teams of weight issues and equipment requirements.
Unstable co-morbid disease	Review recent bloods; optimise unstable diabetes or cardiac disease if necessary— poor diabetes control may affect healing (e.g. skin); chronic angina with frequent episodes, may require GTN spray. Consult senior decision maker/ local guidance if patient has ICD/pacemaker.
Pre-surgery prep	Provide preparation instructions and preoperative tests, e.g., photographs, at listing before procedure.
Patient-centred needs	Address communication, language, cultural, spiritual, social, physical, mental needs; deliver patient-centred care.
Consent	Obtain consent like any surgery; address incapacity issues in informed consent process.
Documentation	Review essential documentation; ensure single listing-to-discharge pathway with demographics, screening, MECC captured.

Quick reference table: Antiplatelet and anticoagulation medications

Anti-platelet	Anti-coagulation
Clopidogrel	Warfarin
Ticagrelor	Apixaban
Prasugrel	Edoxaban
Dipyridamole	Rivoraxaban
Cilotazol	Dabigatran
Aspirin	Enoxaparin
	Heparin
	Fondaparinux

Appendix: Example protocol for local anaesthetic cases in patients with Internal Cardioverter Defibrillators (ICDs)

Shared by Paul Harris, Consultant Anaesthetist at Royal Devon University Healthcare NHS Trust

Management of LA cases

Managing LA cases on patients with ICDS should be safe in a variety of settings but should be avoided in single theatre sites e.g. Tiverton / Exmouth where there is no back up should an emergency arrhythmia occur.

It is important that there is a responsible ILS or ALS trained professional who will be responsible for the patient during the case, and this should NOT be the operating surgeon, who will not be able to focus all their attention on the patient's haemodynamics.

It is important that the consequences of applying a magnet are fully understood it is imperative to understand that the implications of a magnet are different for standard pacemakers (i.e. without ICD functions).

Principles of ICDs

Internally placed electronic devices for patients at risk of a malignant arrhythmia i.e. ventricular tachycardia or ventricular fibrillation, thus they serve as ANTI-TACHYCARDIA devices.

Primary prevention is for those at risk of sudden cardiac death, secondary prevention is for those who have already survived a malignant arrythmia e.g. post myocardial infarction

ALL intravascular ICDs have FULL pacemaker capabilities thus will have anti-tachycardia therapies (overdrive pacing, DC cardioversion, defibrillation) AND ANTI-BRADYCARDIA therapies (pacing for heart blocks).

Types of ICD encountered:

Intravascular – shock coil always on the Right Ventricular (RV) Lead

- Patient may just have RV lead, and no pacing indication e.g. Brugada Syndrome, long QT syndrome
- Patient may have dual leads, RV and Right Atrium, for both pacing need and VT/VF treatment
- Patient may just have RV lead but also need pacing e.g. Atrial Fibrillation plus risk of VT/VF

- Patient may have CRT-D (see below)

Subcutaneous – NOT intravascular (S-ICD)

- Patient at risk of VT/VF but NO pacing need, thus avoids intravascular leads
- Only ICD that does not function as a pacemaker (except brief post-shock pacing)
- Box larger and normally sited in left axilla E.g Brugada, hypertrophic cardiomyopathies

CRT-D = Cardiac Resynchronisation Therapy-Defibrillator

- CRT devices are used for patients with confirmed heart failure, thus ejection fraction <35% AND left bundle branch block, and has an RV and LV lead +/- RA lead
- By definition they have structural heart disease and will be the ICD sub-group most at risk of developing a malignant arrhythmia and possibly lower chance of successful termination of VT/VF than a patient with a structurally normal heart
- CRT-D patients will almost always be 100% paced as this LV/RV pacing improves ventricular performance. This will have implications for surgery and the use of a magnet

Magnet Application

- A magnet place over the ICD box will INHIBIT all anti-tachycardia therapies
- It will NOT affect anti-bradycardia settings AT ALL, thus if ICD patient is paced, a magnet will not change the pacing functions
- A magnet MUST be used for any surgical case where either bipolar or monopolar diathermy is being used as the ICD will read the electrical interference from diathermy as VT / VF and will deliver a shock
- BUT, if patient is pacing dependent then the diathermy will also inhibit the pacing of the device. This is different from a pacemaker, where a magnet applied will change the pacemaker to an asynchronous rate at around 100 beats/minute.

Important note:

- A magnet will leave patient unprotected from a malignant arrhythmia should it occur, thus they must be monitored very closely
- Patients may be at greater risk of developing VT / VF during the procedure than any other day due to circulating catecholamines from stress, anxiety, pain
- Removal of the magnet should revert the ICD to normal function and treat VT/VF

Guideline for managing LA cases for patients with an ICD in situ

1. Determine the type of device i.e. single RV lead, dual chamber PPM ICD, S-ICD, CRT-D
2. Ensure device checked within last 6 months
3. Patient should have an ECG within last 12 months to look for pacing or atrial fibrillation, and urea & electrolytes within 6 months. Potassium should be greater than 3.4mmol/L
4. READ the check report:
    - Is patient paced at all and if so how much?
    - CRT-D patients are likely near 100% LV/RV paced, even if no heart block
    - Has device treated any tachycardia i.e. anti-tachycardia pacing, DC cardioversion or defibrillation for VT/VF, and if so how frequently? This may warn of the likelihood of an event during the surgery
5. Patient needs a dedicated ILS trained health professional responsible for their care during the case
6. 3-lead ECG, Blood pressure and oxygen saturations should be used and recorded every 5 minutes
7. Crash trolley, defibrillator and pads should be immediately available but application of defibrillation pads should not be necessary
8. Briefing should focus on the potential risks of having an ICD patient on the list
9. Patient should have intra-vascular access with a cannula
10. Patient should be prepped and local anaesthetic administered with device still active (slight increased risk of VT/VF therefore device will confer protection)

11. Before knife to skin, magnet applied to box (either standard or S-CD box)

Patient will now NOT be protected against VT/VF thus will need monitoring, vigilance, attention to any symptoms, palpitations, change in observations. If in doubt, STOP case and remove magnet

12. If patient develops any arrhythmia or change in rhythm on ECG, STOP case and remove magnet so device can analyse and treat appropriately

13. When magnet applied, case can start and time is recorded. Magnet will inhibit all tachytherapies thus will NOT shock, but will NOT inhibit pacing

14. But, diathermy may inhibit pacing if patient is paced (monopolar greater risk than bipolar). This will have implications if patient completely pacing dependent (known from pacing report) OR has CRT-D as the biventricular (LV/RV) pacing will be used to improve myocardial performance, thus patient may become symptomatic if this is inhibited.

15. At end of case, removal magnet. Physiologists do not need to be made aware and device does NOT need further ICD check.

16. Patient should go to Recovery for 30min before returning to the ward and have regular observations so ensure no haemodynamic instability

References

#	Recommended Document	Author	Overview
	Guidelines and research		
1	How to set up a one stop cataract pre assessment clinic	GIRFT	A practical guide to delivering pre-assessment ahead of cataract surgery in one patient visit.
2	UKCPA Handbook of perioperative medicines	UKCPA	A reference guide to perioperative medicines.
3	Support guide for implementation of early screening, risk assessment and optimisation	GIRFT	Operational guidance to advise NHS trusts on how to meet early screening, risk assessment, and optimisation requirements.

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About GIRFT and the GIRFT Academy

Getting It Right First Time (GIRFT) is a clinically-led national programme designed to identify and minimise unwarranted variation in treatment and care delivered. It undertakes clinically-led reviews of specialties, combining wide-ranging data analysis with the input and professional knowledge of senior clinicians to examine how things are currently being done and how they could be improved.

The programme has the backing of the Royal Colleges and professional associations and has a significant and growing presence on the Model Health System portal, with its data-rich approach providing the evidence for hospitals to benchmark against expected standards of service and efficiency.

The GIRFT model has now been applied in more than 50 different areas of clinical practice. It consists of five key strands:

1) Data Gathering – a broad data gathering and analysis exercise, generating a detailed picture of current national practice and outcomes.
2) Peer Reviews – direct clinical engagement via visits or virtual meetings between clinical leads and trust teams; an opportunity to examine trust behaviour in the context of the national picture, enabling teams to understand where they are performing well and what they can do better.
3) National Report & Academy resources – production of national reports that draw on data analysis and discussions with provider teams to identify opportunities for improvement, locally, regionally and nationally, alongside - clinical resources such as best practice pathways and guides.
4) Support to deliver – the implementation phase where the GIRFT team supports trusts, commissioners and integrated care systems to deliver the improvements recommended.
5) Research & Development – GIRFT fellowships support resident doctors, nurses and allied health professionals to develop their research and clinical improvement skills, delivering research projects and GIRFT identified improvements in their host provider, system or region.

GIRFT Academy has also published other pathways and case studies which are available via FutureNHS. These are available at: *Anaesthesia and Pre-Operative Medicine (APOM) - Getting It Right First Time - FutureNHS Collaboration Platform*

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