Perioperative Medicine SIG 21018
Measuring, Managing and Minimizing Risk

Two sides to the same coin: Heads-medical administrator. Tails –colorectal surgeon

Assoc. Prof. Bruce P Waxman OAM FRACS AFRACMA
Two sides to the same coin

Medical administrator
CMO Bass Coast Health

Colorectal Surgeon
Monash Health & RACS
Two sides to the same coin

Heads:

Chief Medical Officer
Bass Coast Health
Wonthaggi Hospital
South Gippsland Coast
Victoria

Tails:

Colorectal Surgeon (retired)

Adjunct Associate Professor (Honorary)
Monash University
Dept. of Surgery
School of Clinical Sciences Monash Health
Clayton
Victoria
Heads: Medical Administrator
Contents

• Bass Coast Health and VMOs
• Clinical Governance Reform
  • Competency Framework
  • Capability Framework /Role delineation
  • Risk management for perioperative services
  • Amber meetings: MDT for perioperative anaesthetic assessment
Bass Coast Health

Major provider of public health in the Bass Coast Shire in Southern Gippsland. Integrated service that provides hospital, aged care and primary and community care health services across the shire.
Wonthaggi Hospital : VMOs

Visiting Medical Officer (VMO) Service Profile as at October 2018 N = 45  EFT= 7.6

1. General practitioners: all from Wonthaggi Medical Group (WMG).

Provide all inpatients services:

Medical and Sub-acute ward based care: GPM

*Anaesthesia and post-op surgical care: GPA*

Maternity services including LUSCSs: GPO

2. A range of specialist surgeons who consult and perform elective surgery:

General surgery, Orthopaedic surgery, ENT, Gynaecology, Ophthalmic surgery, Urology,

Plastic surgery and Gastroenterology – 1-2 days / month
Clinical Governance reform

- Board concern re Clinical Governance (CG)
- Change in Executive with new CEO
- Lack of CG systems, processes and information
- Lack of Health Service control over hospital processes (admissions, discharges and flow)
- Some Clinical Incidences
- Working outside Capability
- Low Self Sufficiency (46%)
- Djerriwarrh context

Front page in local newspaper
March 2016
Clinical Governance Review

External consultant undertook a comprehensive clinical governance review

All Services targeted

July 2016 report - 29 recommendations

Recommendation 23 relevant to Competencies and Capabilities:

*BCH should review contracts and processes to ensure that all clinical staff are appropriately qualified, are practising within their defined scope of clinical practice and the capability of the health service and that staff undertake mandated professional development and meet required mandated competencies.*
Clinical Governance Review: Implementation

- Board of Directors
- Quality & Clinical Governance Committee
- Clinical Governance Steering Committee
  - Medical/Sub-Acute Clinical Governance Implementation group
  - Surgical Services Clinical Governance Implementation group
  - Maternity Services Clinical Governance Implementation group
  - Emergency Services Clinical Governance Implementation group
Competency Framework

Competency Framework for discipline specific credentialing and mandatory training

**Components:** e.g. GPA

**Discipline qualification:** FRACGP DA

**Discipline mandatory training:**
ALS, Neonatal resuscitation/APLS
SIM Centre Emergency Procedures
Peer review/audit
Deployment to Metro hospital

**CPD:** JCCA registered

**BCH Mandatory training:** Hand Hygiene etc.

**Annual Performance Development Review (PDR);**
With CMO
Clinical Service Capability Framework
CSCF

BCH Anaesthesia and Surgery CSCF

Every other state has a CSCF except Victoria

Safer Care Victoria has promised one since 2016, but none likely for at least two years

So we developed our own based on the NSW Health Guide to Role Delineation of Clinical Services model* as a Level 3 Hospital

Vital for BCH to make it clear to our VMOs especially GPAs about our capability, and reduce risk.

Formed the basis of our traffic light preoperative anaesthetic assessment Amber Meeting, initiated by Poranee Buttery FANZCA who we appointed as Clinical Director of Anaesthesia, To provide clinical governance for our GPAs

*NSW Health Guide to the Role Delineation of Clinical Services (2018)
Risk management for perioperative services

Identified 3 key risks and provided solutions

1. Surgical access model

Risks:
- Limited information for planning
- No Request for Elective Admission (REA)
- Surgeons managed their own waiting list
- Pre-anaesthetic assessment (PAA) a ‘rubber stamp’

Solutions:
- Appoint Elective Surgery Access Co-Ordinator (ESAC)
- Add REA and Patient Health Questionnaire
- Develop CSCF
- Upgrade the PAA and add STOP BANG for OSA, common in BCH
- Amber meetings co-ordinated by ESAC
Amber meeting

Structure
Multidisciplinary
Chair/Co-Ordinator: ESAC
Members:
Clinical Director of Anaesthesia
GPA
Chief Medical Officer (surgeon)
NUM Operating Theatre & Ward
Clinical Services Operations Manager: Operating Theatre

Function
Review all PAA identified by ESAC as High Risk e.g. ASA >2 or outside CSCF

Benefits
Improved risk management
Authentic dialogue
Patient focused solution
Education of all involved
Obstructed Sleep Apnea (OSA) & STOP BANG

Snoring (loudly)
Tired, fatigued or sleepy
Observed apnea
Pressure. High Blood Pressure

BMI > 35
Age > 50 years
Neck size > 43 for men >41 for woman
Gender = male

Score one point for each positive item Total = 10
Score > 5 High risk of OSA

Risk management for perioperative services

Identified 3 high risks and provided solutions

2. GPA model of anaesthetic service
   Risks:
   - Variable training
   - JCCA compliance
   Solutions:
   - Engagement with PAA reform including STOP BANG
   - Amber meetings
   - JCCA CPD registration
   - Upgrade peer review meetings with GPAs
Risk management for perioperative services

Identified 3 risks and provided solutions

3. Operating theatre culture

Risks:
- Working together but alone
- Under pressure and at times angry
- Unable to respond to crisis with a group lens.
- Crisis response as individuals

Solutions:
- Working as a team
- Better understand the drivers
- Reduce isolation
- Opportunities for learning
- Random acts of Kindness
Tails: Colorectal surgeon and RACS
Contents

- Pre-operative strategies
- Surgeons’ view of perioperative ‘physicians’
- WHO Surgical Check List and Cockpit Resource Management
- Post-operative strategies: ERAS
- Hospital Acquired complications (HAC)
- Bundle of Care to reduce SSIs
- Operating with kindness: using the K-ISBAR tool at handover
- Reflective Practice
- RACS: Operating with Respect
Pre-operative strategies

Pre-operative risk assessment and work up including POM physician

MDT Meetings:
1. Surgical Plan: Surgeon/Oncologist/Radiation Therapist
2. Shared Decision Making

Preadmission Clinic and Pre-anaesthetic assessment*


The 71 patients admitted through the preadmission process had a 10.7-day average length of stay compared to 18.4 days if the patients were admitted directly by the surgeon
A valued colleague

Early and ongoing review of surgical patients with medical conditions

Consistent, accessible advice to support surgical teams

Facilitate onward subspecialty referral/transfer of care to medical teams

Mutual sharing of skills

Acute management of medical conditions in surgical patients

Caring and sharing the load

Perioperative management of fluids and medications!
## WHO Surgical Safety Check List

**Before induction of anesthesia**

- **BRIEFING**
  - Lead – Circulator or Anesthesiologist
  - Patient verification
    - Identity
    - Consent
    - Procedure
    - Site
  - Site marked/Not applicable
  - Allergies/Precautions
  - VTE prophylaxis
  - Equipment/instrument/implant concerns?
  - Anesthesia safety check
  - Difficult airway / Aspiration risk?
  - Risk of > 500ml blood loss?
  - Postoperative destination

**Before skin incision**

- **TIME OUT**
  - Lead – Surgeon
  - Team members are identified
  - Team verbally confirms
    - Correct Patient
    - Correct Procedure
    - Correct Site
  - Antibiotic prophylaxis given within the appropriate timeframe?
  - Essential imaging displayed?
  - Team communicates anticipated complications

**Before patient leaves operating room**

- **DEBRIEFING**
  - Lead – Circulator
  - Nurse verbally confirms with entire team
    - Procedure performed
    - Identification and handling of Specimen
    - Instrument, sponge, and needle counts are correct (or n/a)
    - Equipment problems?
  - Surgeon reviews with entire team
    - Important intra-operative events
    - Management plans
  - Anesthesiologist reviews with entire team
    - Important intra-operative events
    - Recovery plans
    - Normothermia maintained
  - Is there anything we could have done better?

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STOP!

ANY QUESTIONS FROM TEAM?
Cockpit Resource Management

Applying lessons learnt in the aviation industry to the Operating Room to improve safety and reduce risk

Cockpit Resource Management (CRM) is a set of training procedures for use in environments where human error can have devastating effects.

Used primarily for improving safety, CRM focuses on:
- interpersonal communication
- leadership
- decision making
Human factors in the OR

Diagram:
- Individual
  - Culture
  - Operational atmosphere
  - Communication
- Team
  - Situational awareness
- Decision
- Safety/Efficiency
- Procedures
- Stress/Workload
- Sleep/Fatigue
Figure 1 Main elements of the ERAS protocol.
ERAS: Accelerated recovery protocol
1. Pressure injury
2. Falls resulting in fracture or intracranial injury
3. *Healthcare-associated infection*
4. *Surgical complications requiring unplanned return to theatre*
5. Unplanned intensive care unit admission
6. Respiratory complications
7. Venous thromboembolism
8. Renal failure
9. Gastrointestinal bleeding
10. Medication complications
11. Delirium
12. Persistent incontinence
13. Malnutrition
14. Cardiac complications
15. Third and fourth degree perineal laceration during delivery
16. Neonatal birth trauma

Bundle of Care in reducing SSIs

The Bundle

1. Antibiotic prophylaxis, administered up to 60 minutes before incision
2. Skin preparation with 2% chlorhexidine in 70% alcohol
3. Maintenance of normothermia in the perioperative period
4. Use of supplemental oxygen in the early postoperative phase
5. Maintain systolic blood pressure > 100mm Hg

A bundle of care to reduce colorectal surgical infections: an Australian experience
J Hosp Infect. 2011;78:297-301

The infection rate fell from 15% [95% confidence interval (CI) 10.4-20.2] before the project to 7% (95% CI 3.4-12.6) 12 months after the project
Operating with kindness to improve collegiality, at handover

Why are doctors so unkind to each other? What has happened to collegiality?

**Collegiality** is work environment where responsibility and accountability are shared equally by colleagues, with mutual respect.

**Kindness** gets its roots from the old English word, *cynd*, meaning ‘nature, family and lineage’ and hence kinship.

The wish to co-operate, be generous and thoughtful, and treat others, like members of their family

**Reflect** on your own behaviour and be kind to your colleagues.

A good time to do that is at handover.

Use **K-ISBAR**, to improve collegiality, with kindness as the catalyst and clinical handover as the tool

*Brewster D & Waxman B*

*Adding kindness at handover to improve our collegiality – the K-ISBAR tool*

*Med J Aust 2018; 209: In Press*
Reflective practice

Mirror mirror on the wall who is the best surgeon of them all?

*Not you kid!*

Why, is it how do others perceive my behaviour?

May be it is me that is the problem?

*A surgeon with insight!*
The Operating with Respect (OWR) course provides advanced training in recognising, managing and preventing discrimination, bullying and sexual harassment.

**Mandatory for all surgeons**
“Adopt as your fundamental creed that you will equip yourself for life, not solely for your own benefit but for the benefit of the whole community.”

Sir John Monash, engineer, WW1 military commander and public administrator (1865–1931)