Pre-operative Assessment
The Role of the Anaesthetist

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SECTION 2 - BACKGROUND

In the light of recent Government initiatives in the area of pre-operative assessment and with the requirement on Trust Management to assume, through Clinical Governance, shared clinical responsibility, there has been increasing concern among anaesthetists as to what exactly is the role and the responsibility of the anaesthetist in the pre-operative period.

The NHS Modernisation Agency through The National Pre-Operative Assessment Project is producing guidelines in this field. These are of a more generic nature and encompass all aspects of pre-operative assessment dealing more comprehensively with the policies, procedures and personnel involved. This working party is specifically concerned that the particular role of the anaesthetist is clearly understood.

When the current project on evidence-based guidance is complete, there will be specific guidelines issued through NICE on routine pre-operative testing.

The working party is grateful for the input to this document of the National Pre-operative Assessment Co-ordinator as both the AAGBI and the national guidelines published by the NHS Modernisation Agency are in agreement as to the pivotal importance of the anaesthetist's role.

SECTION 3 - INTRODUCTION

The anaesthetist is uniquely qualified to assess anaesthetic risk.

Anaesthetists are responsible for the pre-operative assessment of patients whom they anaesthetise.

In-patients are frequently admitted on the day of major surgery. There is thus little time for the anaesthetist to assess patients adequately.

The Association of Anaesthetists of Great Britain and Ireland (AAGBI) is concerned that Trusts and hospitals recognise the necessity of pre-operative assessment.

The appropriate standard of care includes an opportunity for patients to be seen by the anaesthetist prior to surgery.

These guidelines set out good practice for pre-operative assessment. The subject has been referred to in other AAGBI publications [1-3], but its importance is such that it merits further consideration.

Business planning by Trusts and anaesthetic departments should ensure that the necessary time and resources are directly targeted towards pre-operative assessment.

It is important that the patient's views are considered in the process of pre-operative assessment (Appendix 1).

SECTION 4 – GOOD PRACTICE

All patients should be seen by an anaesthetist before undergoing an operation that requires the services of an anaesthetist.

Ideally, this should be the doctor who is to give the anaesthetic.

The responsibility for ensuring that appropriate pre-operative assessment has been carried out rests with the most senior anaesthetist for the given operating list. If that person is a trainee or non-consultant career grade (NCCG), advice must be available from a duty consultant.

All patients should have had a basic physical examination of the cardiovascular and respiratory systems conducted by a medical practitioner.

The anaesthetic room is not the appropriate place for an anaesthetist to see an unassessed patient for the first time prior to surgery. The hospital system must allow time for patients to be seen pre-operatively by the anaesthetist. If this is not the case, elective operations may have to be cancelled.

The pre-operative visit also provides an ideal opportunity for teaching trainees and other healthcare staff about pre-anaesthetic assessment.

SECTION 5 – THE OBJECTIVES OF PRE-OPERATIVE ASSESSMENT

The aim in assessing patients before anaesthesia and surgery is to improve outcome.

This is achieved by:

- identifying potential anaesthetic difficulties
- identifying existing medical conditions [4]
- improving safety by assessing and quantifying risk
- allowing planning of peri-operative care
- providing the opportunity for explanation and discussion
- allaying fear and anxiety (Appendix 1)

This will only be achieved when all health professionals work as a team [2].

Good pre-operative assessment will help to:

- reduce costs [5]
- increase efficiency of operating theatre time [5]

Such action should:

- reduce the number of patients who fail to attend on the day of surgery [4]
- reduce cancellation of surgery for clinical reasons [6]
- provide an opportunity to discuss with patients any self-help matters to improve outcome (e.g. stopping smoking or losing weight).

Patients should have access to easily understood information. Such information may be conferred through patient advocates or via information sheets in an appropriate language.

SECTION 6 – THE ROLE OF THE ANAESTHETIST

The anaesthetist is responsible for deciding whether a patient is fit for anaesthesia.

While other professional groups may be involved, it is the anaesthetist who provides the framework in which a valid assessment can be made.

It is important to be clear about the boundaries between the remit of the pre-anaesthesia screening team and the responsibilities of the anaesthetist.

The Association of Anaesthetists states that 'It is inappropriate for a non-anaesthetist to promise a particular type of premedication, anaesthesia technique or postoperative pain management', and that 'The decision to proceed [with anaesthesia] cannot be delegated' [2].

With previously screened healthy patients, the anaesthetist, on the day of surgery, must check the results of screening and of other pre-operative testing. Any tests performed pre-operatively must be available to and read by the anaesthetist.

Patients likely to present anaesthetic problems should have been previously identified and seen by an anaesthetist prior to being scheduled for surgery. This is often done on an ad hoc basis but it is more efficiently carried out in an anaesthetic pre-operative assessment clinic.

The anaesthetist should explain the proposed anaesthetic procedure. There is often a choice of anaesthetic technique and the anaesthetist must ensure that the advantages and complications of each are explained to the patient.

SECTION 7 – SCREENING AND ASSESSMENT

The provision of a pre-operative screening and assessment service improves efficiency and enhances patient care.

The screening and assessment process is increasingly carried out by a specifically trained pre-assessment team [7,8].

Nursing and other trained staff play an essential role when, by working to agreed protocols, they screen patients for fitness for anaesthesia and surgery.

Nurses and operating department practitioners (ODPs) are NOT qualified to decide whether a patient is fit for anaesthesia or surgery. They can, however, play an invaluable role in identifying problem patients by using agreed questionnaires.

Nurses work to an agreed job description and are professionally accountable to the United Kingdom Central Council (UKCC). Trusts are vicariously liable if such staff is negligent. Nurses accept responsibility after they have received appropriate training, and work within agreed competencies. The role of the ODP may well develop in a similar manner in the future.

Access to an anaesthetist by pre-operative assessment personnel is essential.

1 Purpose of pre-assessment

The screening and assessment process enables the identification of those patients who require:

- few or no pre-operative investigations
- targeted investigations, the results of which must be available when the anaesthetist sees the patient in the immediate pre-operative period
- further investigations or treatment before being referred for anaesthetic assessment prior to admission for surgery
- further assessment or referral after specific investigations.

An ideal system allows pre-operative assessment staff to refer patients directly for optimisation when medical problems are detected.

2 Methods of pre-assessment

Questionnaires are an effective way of gleaning basic background information.

They may be given to the patient at the surgical outpatient clinic to be completed immediately or taken home for completion and returned by post. Admission staff may conduct a question and answer interview, to agreed protocols, at the clinic [sample questionnaires are shown in Appendix 2]. Screening may also be done by telephone from agreed questionnaires.

The screening and assessment process may be performed in the Primary Care Trust (PCT) or by the general practitioner before a patient is referred for a surgical opinion. Suitable patients can then be given a date for direct admission. Guidance from anaesthetic and surgical directorates can be provided for pre-operative assessment requirements.

Anaesthetists may be able to access the results of screening, pre-operative assessment and investigations when an integrated computerised record system or a ‘smart card’ system is employed.

Patients are often screened and assessed immediately following the surgical consultation. This fast track process allows a date to be given for the proposed surgery (subject to satisfactory laboratory and other investigations).

SECTION 8 – THE ANAESTHETIC PRE-OPERATIVE ASSESSMENT CLINIC

Anaesthetic pre-operative assessment clinics provide the opportunity for anaesthetists to see those patients who have been identified by screening and assessment as presenting potential anaesthetic problems.

The anaesthetic pre-operative assessment clinic must involve consultant anaesthetist presence which is recognised as a fixed commitment within a job plan.

The clinic must be fully resourced with staff and equipment.

There should be facilities for interview and examination of patients, phlebotomy and other pre-operative testing such as X-ray and electrocardiography (ECG).

Such clinics are an efficient and convenient method of pre-operative assessment and patients should ideally be seen within two weeks of admission for surgery. Efforts should be made to coordinate this with any other hospital attendance.

In order for the clinic to function efficiently:

- the patient’s full hospital record must be available to the anaesthetist
- the patient should have an opportunity to talk to an anaesthetist, ideally the one who will administer the anaesthetic
- a surgical or anaesthetic house officer should perform the preliminary clerking and examination
- the patient should have an opportunity to meet other professionals that will be involved in their care, for example members of the pain team or a stoma care nurse or dietician.

The advantages of assessing patients in a pre-operative anaesthetic clinic include:

- patients identified by screening as requiring further assessment can be seen
- patients can be seen in ‘office hours’
- patients admitted for same day surgery will have had time to have been adequately assessed
- risks and side effects can be fully explained and documented as having been discussed
- elective postoperative admission to an intensive care or high dependency unit can be organised and explained.

SECTION 9 – INVESTIGATIONS

Blanket routine pre-operative investigations are inefficient, expensive and unnecessary.

Medical and anaesthetic problems are identified more efficiently by the taking of a history and by the physical examination of patients.

Departments should have policies on which investigations should be performed. These should reflect the patients' age, co-morbidity and complexity of the surgery.

No investigations are required prior to minor surgery in otherwise healthy patients. A clear demarcation is necessary between health screening and investigations that will add something to the anaesthetic management.

Pre-operative investigations can themselves be the cause of morbidity [9, 10].

An ECG should be performed on every patient with a cardiac or related history but is not indicated for asymptomatic males under the age of 40 years or asymptomatic females under the age of 50 years [10].

Local protocols will indicate which laboratory tests are required but generally a haemoglobin (Hb) result is only required if the history indicates the Hb may be low or where it is anticipated there may be significant blood loss at surgery.

Routine biochemistry is indicated only in those patients whose history or current medication makes it necessary [11].

Chest X-rays should be arranged in accordance with the recommendations from the Royal College of Radiologists [12] in conjunction with local hospital policy.

SECTION 10 – FASTING POLICIES

For safety reasons, patients should not eat or drink immediately prior to anaesthesia.

The AAGBI recommends the minimum fasting periods based on the American Society of Anesthesiologists (ASA) guidelines:

- 6 hours for solid food, infant formula, or other milk
- 4 hours for breast milk
- 2 hours for clear non-particulate and non-carbonated fluids

Each hospital and Trust should have agreed written policies.

It is important that the elderly, those who have undergone bowel preparation, sick patients, children and breast-feeding mothers should not be left for long periods without hydration. They may require intravenous fluids prior to surgery.

The order of an operating list as printed should not be changed thus ensuring patient safety and comfort.

The chewing of gum is controversial but the pragmatic approach is to treat it as if it were an oral fluid and prohibit for 2 hours pre-operatively. The greatest danger is of a foreign body potentially blocking the airway.

SECTION 11 - REFERENCES

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APPENDIX 1

The patient's perspective on the pre-operative visit

The anaesthetist's pre-operative visit to the patient is important to patients for creating trust and confidence. Meeting the anaesthetist whom the patient will see again in the anaesthetic room establishes a relationship between them. The recognition that takes place between people on seeing each other again is special. The patient will feel reassured that the anaesthetist sees him or her as a person to be protected from harm as well as given technically safe care.

As part of that relationship, the patient will want to know the anaesthetist's name and status. If the anaesthetist is still in training, the patient will want to know that the consultant has judged that his or her levels of competence and experience are appropriate and that the consultant will be to hand if necessary. Patients are usually sympathetic to doctors in training and want to help them. But they do not like doctors in training falling back on the title 'doctor' by way of sole introduction.

Unless this has already been done in an assessment clinic, the pre-operative visit is the time to discuss the choice of anaesthetic method in the light of the patient's preferences, his or her clinical state, the operation itself and the anaesthetist's preferences and special skills. This dialogue brings in discussion of risks and benefits. Only the patient can know how much detail he or she wants, so the anaesthetist has to check this with the patient as the discussion goes along. This is also the time for the patient to be helped to raise any doubts and questions about any aspect of anaesthetic care. And this is the time for gaining the patient's explicit consent to what is agreed.

So far, discussion between anaesthetist and patient is personal and particular, in some sense an alliance between the two. But when there are severe constraints on anaesthetists' time, some of the more routine things patients want to know can perhaps be imparted by someone else. They include how the patient will get to theatre (is there a choice?), what will be experienced in the anaesthetic room or, for a conscious patient, the theatre; what will be experienced in the recovery room (or in ICU, if that is planned); what time the operation is scheduled (with a prompt explanation if the time slips); how postoperative and post discharge pain control will be managed and what choices there may be for those. If the patient is to wake up with an epidural or PCA apparatus in place, intravenous lines, oxygen mask, etc., those too must be explained. There should be as few surprises as possible, for surprises are alarming.

One further point: how the patient wishes to be addressed should be noted. This is mainly a matter of courtesy and respect. But patients in recovery addressed in an unexpected way may not recognise themselves under an unfamiliar name, and this is an avoidable surprise. Quality of care is made up of minor things as well as major.

Finally, a postoperative visit, however brief, by the anaesthetist completes the patient's good experience.

Charlotte Williamson - Chair, RCA Patient Liaison Group

APPENDIX 2a

PRE-SCREENING QUESTIONNAIRE

(This form to be posted to patient with appointment for screening)

Patients Identification Details

Name: _____

Address: _____

_____ Postcode: _____

DoB: _____ Hospital No: _____

Admitting Consultant _____ Specialty: _____

Proposed Operation: _____ Screening clinic date: _____

Please complete this questionnaire at home and bring it with you when you come to the hospital. It will help us to make plans for your care. It will be treated as confidential medical information.

A Parent, Guardian or Carer may answer on the patient's behalf.

What would you like us to call you?
(for example, as Mr or Mrs, or by your first name)_____

Have you ever suffered from any of the following? (if 'yes', please give details)

Heart disease of any sort YES / NO _____
Chest pain, palpitations or blackouts YES / NO _____
High blood pressure YES / NO _____
Rheumatic fever YES / NO _____
Asthma, bronchitis or other chest disease YES / NO _____
Breathless on exertion or at night YES / NO _____
Diabetes or sugar in the urine YES / NO _____
Kidney or urinary trouble YES / NO _____
Convulsions or fits YES / NO _____
Anaemia or other blood disorders YES / NO _____
Bruising or bleeding problems YES / NO _____
Blood clots in the legs or lungs YES / NO _____
Jaundice (yellowness) YES / NO _____
Indigestion or heartburn YES / NO _____
Any other serious illnesses YES / NO _____

Do you smoke, or have you stopped recently?
(if 'yes' how many a day?) YES / NO _____

Do you drink alcohol
(if 'yes' how much a week?) YES / NO _____

Do you have false, capped or crowned teeth? YES / NO _____

Do you have a pacemaker or any implants? YES / NO _____

Do you wear contact lenses or a hearing aid? YES / NO _____

Women; Could you be pregnant? YES / NO _____

Are you on the Pill/HRT? YES / NO _____

What is your approximate weight? _____

What is your approximate height? _____

Are you taking any medicines or drugs? YES / NO _____
(including inhalers, eyedrops, creams,or herbal remedies, whether prescribed by your doctor or not) _____

Are you allergic to any drugs or materials? YES / NO _____

Please list any previous operations or anaesthetics

_____ Year: _____

_____ Year: _____

_____ Year: _____

Have you, or any member of your family,
had any problems with anaesthetics? YES / NO _____

Is there anything else which your anaesthetist
or surgeon should know? YES / NO _____

Do you have particular cultural or religious needs YES / NO _____

Do you understand that you must not drink alcohol, drive or operate any machinery for 48 hours after your anaesthetic? YES / NO _____

Do you need the services of an interpreter YES / NO _____

For Day Surgical Patients only:

Will you have someone to take you home by car? YES / NO _____

Will you have a responsible adult at home to look after you overnight? YES / NO _____

Will you have easy access to a telephone? YES / NO _____

Signature: _____ Date: _____

APPENDIX 2b

PAEDIATRIC DAY CARE UNIT
PRE-OPERATIVE ASSESSMENT

Patient label:

DATE OF SURGERY _____

DIAGNOSIS _____

PROPOSED PROCEDURE _____

PAST MEDICAL HISTORY

	NO	YES	DETAILS
Has your child been admitted to,or frequently attends hospital?			
Has your child attended a doctor in the last 4 weeks?			
Has your child had any of the following symptoms in the last 4 weeks: high temperature,rash, cough, cold, sore throat?			
Has your child been in contact with an infectious disease in the last 4 weeks?			
Has your child any heart problems?			
Does your child have a history of asthma or chest problems?			
Has your child any kidney problems?			
Has your child ever been jaundiced?			
Does your child bruise easily?			
Has your child ever had any convulsions or seizures?			
Does your child have any other medical conditions?			
Was your child born prematurely (i.e before 37 weeks)?			

APPENDIX 2c

PAEDIATRIC DAY CARE UNIT

TELEPHONE CHECKLIST

PATIENT NAME: _____ TELEPHONE NO: _____

DATE OF CONFIRMATION: _____ TIME: _____

DATE OF ADMISSION: _____ CONSULTANT: _____

	YES/NO	COMMENTS
Have you read and do you understand the fasting instructions in the letter?		
Is your child currently suffering from cough, cold or any other illness?		
Is your child currently taking any medication?		
Does your child have a heart condition or any other medical condition? If yes, which hospital do they attend?		
Do you have any family history of reactions to anaesthetics?		
Has your child had a general anaesthetic within the last 4 weeks?		
Has your child received any immunisations or vaccinations within the last 4 weeks?		
Do you need any directions to the Hospital or the DCU?		

FROM WHOM WAS THIS INFORMATION OBTAINED: _____

SIGNATURE OF NURSE _____

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