Perioperative awareness

I spent some time recently going through the Health Professions Council (HPC) and the Nursing and Midwifery Council (NMC) hearings and was intrigued by the reasons for suspending or striking off registrants. In one particular case, the 57-year-old registered nurse on night duty failed to carry out the necessary patient observations due to sleeping on duty. Another case, one that is more alarming, a health worker dragged their ‘patient along the floor, leaving the medication trolley unlocked and unattended’ was charged in breach of the trust’s policy.

But one particular case that we should all be aware of, is the case of a registered health professional who inadequately performed record keeping and encouraged another colleague to carry out actions outside their sphere of competence, ultimately placing the patient at unnecessary risk.

It is important that what we do and say is indeed within the boundaries or scope of practice and conduct. Our duty of care is integral to our practice but so is our self-awareness. This is at the centre of a new movement to implement interprofessional learning (IPL) within perioperative practice. Paul Wicker offers his viewpoint on the purpose of IPL among different professional groups. He describes the benefit of how each practitioner can start to understand each other’s priorities, skills and knowledge and how it is essential to building effective team working. I guess some would argue that this has been around for a long time, so what is new? If anyone has experience of IPL, perhaps they could share their views in the next JPP.

Luke Ewart’s examination of the evidence around awareness with explicit recall (AER) following general anaesthesia also brings awareness under anaesthesia to the forefront of practice. He carefully considers whether AER is reduced using devices such as the bispectral index (BIS) or similar electroencephalogram (EEG) monitoring. What he concluded from the study is that a protocol to guide anaesthesia delivery may help to reduce incidence of AER but is unsure whether the protocol should be guided by the use of BIS devices.

New suggestions or approaches do drive the way forward and show how aware we are and how much we wish to change practice. Kerry Bloodworth, Assistant Director of Nursing shares her experience of implementing The Productive Ward within her trust and can see the opportunities for transferability into the perioperative environment through The Productive Operating Theatre methodology. I would like to invite perioperative colleagues who are involved in implementing The Productive Operating Theatre to share their experience; including how the principles improve patient care and greater efficiency in the perioperative setting.

In this month’s JPP there is an eclectic mix of articles that raise our awareness within and outwith the perioperative setting. It is pleasing that we can share and learn from each other’s experience; armed with this knowledge it will strengthen our practice; allow us to remain self-aware and work within our sphere of competence.

Brian Smith
Editor
editor@afpp.org.uk

FROM THE EDITOR