Dear Editor

Question: Whose job is it anyway??
Answer: Yours and mine!

I write to express concern at the varied responses that I have had in relation to a recent question that I posed to a number of theatre practitioners working in the area of endoscopic surgery. My question was directly relating to the method that exists for the management of fluids used for irrigation during procedures especially in the areas of prostate and gynaecology surgery.

The responses were varied and inconsistent ranging from no fluid management by way of calculating a deficit, to a varied list of tasks such as using the white swab board or scrap paper to provide this information. None of my enquiries yielded an existing protocol in place in any of the hospitals where I made my enquiry.

What was apparent from the discussions that I had with individuals was that there was no knowledge gap in relation to the complications and the risks inherent in these types of procedures. Practitioners were aware of TURP Syndrome - glycine toxicity and the potential risks of generalised fluid overload.

What was inconsistent was the approach to providing ongoing information to the surgeon and anaesthetist relating to the irrigation fluid management input, output and deficit, and where the responsibility for this rested.

There was some consolation in the reality that at least practitioners for the most part were making some attempts to undertake this task, all be it rather ‘hit and miss’ in the majority of cases.

Whilst it is understood that very often the deficit will not add up to a perfect scientific calculation, a good rounded estimate is better than no information at all.

So what is my point? Record keeping, that’s my point. This is an integral part of the care we deliver as perioperative practitioners and an essential component of safe and effective care. Good record keeping is a requirement identified under the professional codes of practice (NMC and HCPC). This is required to provide safe patient care, communication, accountability, potentially identify risks and provide for systems of early detection of complication, providing documentary evidence and sharing of information and communication between all members of the multi disciplinary team.

The principles of good record keeping provide that practitioners should use professional judgement to decide what is relevant and what should be recorded.

Therefore, even in the event that there are no national/ hospital protocols in place which outline the requirements for practitioners to keep account of the irrigation fluids used, and an ongoing estimate of the fluid deficit, it is obvious that giving the vast majority of perioperative staff are aware of the implications of fluid overload and general toxicity, that we should as a matter of course provide an ongoing count of total irrigation fluid used and what the output is, reflecting the deficit which is a crucial piece of information in terms of managing the patient safely. It is my belief that as professionals, accountable for our actions, we should be providing evidence of this having been recorded and communicated to the surgeon and anaesthetist.

All comments will be greatly appreciated.

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