

**SURGERY AND GENERAL ANAESTHESIA
IN
GENERAL PRACTICE PREMISES**

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SECTION I - INTRODUCTION

General practitioners are being encouraged to undertake surgical procedures within their practice premises. Some of these procedures may require general anaesthesia or sedation. The Association of Anaesthetists of Great Britain and Ireland and the Association of Surgeons of Great Britain and Ireland therefore wish to give advice on how an appropriate, modern and safe environment for such patients can be achieved.

The range of procedures which can currently be undertaken by trained general practitioners is outlined in the document HSG (93) 14[1].

It is anticipated that the majority of the work will be minor surgery employing local anaesthesia techniques. However, the Associations have become aware that there may be a wish in certain practices to extend the range of procedures by inviting surgeons to operate on more complex conditions which require general anaesthesia or sedation with local or regional anaesthetic techniques.

The quality of service must be maintained and therefore it is essential that those providing the service are sufficiently well trained and experienced to be able to deal with emergency situations and any complication which may arise either associated with, or as a result of, surgery or the administration of potent, potentially life-threatening drugs and drug combinations.

It is important to emphasise that sedation techniques for surgery or for investigative procedures, such as endoscopy, are not without risk [2,3]. These techniques also require appropriate arrangements for patient monitoring and aftercare.

Both Associations wish to stress how important it is to provide adequate postoperative pain relief, both in the practice premises and following discharge.

Children

Whenever general anaesthetic services are provided for children the facilities and staffing should meet the standards laid down in the Department of Health document 'Welfare of Children and Young People in Hospital' and the Royal College of Anaesthetists' document 'Guidance for Purchasers on Paediatric Anaesthesia'. All staff involved should be appropriately trained and experienced in the treatment of children [4,5].

Surgery in children requiring general anaesthesia or sedation likely to lead to loss of verbal contact should not normally be carried out in general practice premises.

SECTION II - NECESSARY FACILITIES

(i) Personnel

When surgeons or anaesthetists are invited to undertake procedures in practice premises the service must be provided by fully trained surgeons and anaesthetists who are either accredited or, in the future, holders of the CCST or its equivalent in the appropriate discipline.

The service must be consultant based and not provided by unsupervised trainees.

All those involved in providing the service should be trained in resuscitative measures. They should participate regularly in refresher courses and resuscitation drills.

Medical indemnity cover must exist for practice in these circumstances for all staff.

(ii) Support staff

A dedicated, skilled assistant for the anaesthetist must be available.

There must be an appropriate number of trained nursing staff to ensure efficient management of safety of the patients being treated.

There must be a sufficient number of trained and dedicated recovery staff to provide postoperative care.

(iii) Organisational arrangements

There must be a facility for both the surgeon and the anaesthetist to assess all patients pre-operatively. The selection of patients is of paramount importance. This will require access to notes detailing the past medical history of the patient.

There must be facilities for undertaking basic medical investigations on any patient scheduled for surgery, e.g. ECG, Hb estimation.

Methods of patient identification, consent to operation and record keeping must be in accordance with accepted hospital practice.

Before discharge, patients should meet the criteria outlined for those receiving day stay surgery. There must be clearly defined arrangements to ensure that patients receive good postoperative pain relief [6,7].

Mechanisms should be in place to permit the surgeon and the anaesthetist to be contacted for both pre and postoperative advice.

Guidelines should be readily available for the management of rarely occurring complications, e.g. allergic reactions [8].

Arrangements should be in place to ensure that, in the unlikely event of a serious complication, the patient can be transferred quickly and safely to specialist services which should include access to both high dependency and intensive care units. This will require that lines of communication have been developed with identified consultants in the appropriate specialties at nearby hospitals [9].

All procedures undertaken should be subject to medical and clinical audit in accordance with locally and nationally agreed procedures [10].

SECTION III - SPECIALIST SERVICES

(i) Anaesthetic services

- (a) The accommodation provided must be sufficiently large to permit free movement of personnel when dealing with the patient.
- (b) Anaesthetic, monitoring and resuscitation equipment provided must be equivalent to that in a modern operating suite [11].
- (c) There must be immediately available, a full range of drugs and disposables as are provided in a modern anaesthetic room. These must include controlled drugs for which there must be storage and security mechanisms [12].

(ii) Surgical services

All surgical practices must conform with the Royal College of Surgeons Working Party Report on Day-case Surgery (revised edition March 1992) [13].

SECTION IV - STERILISATION SERVICES
- with special reference to HIV and
Hepatitis B cross infection

- (i) It is anticipated that in the majority of cases, sterile supplies will be “bought-in” from an outside agency. Several points need to be addressed:-
- (a) It is the responsibility of both the purchaser and the user of services to ensure that all relevant standards are met [14,15].
 - (b) Decisions must be made on the requirements for the tray service. This will include, for each type of tray:
 - instruments - type and quality
 - swabs - size, type, material and quantity
 - size and quantity of gallipots, receivers, etc.
 - (c) When the frequency and number of patients on the lists to be undertaken has been decided, the total quantity of equipment must be purchased by the user. It is necessary to ensure that sufficient quantities of equipment are purchased to allow for the time spent on transportation to and from the sterile supply centre and the associated re-processing and sterilisation.
 - (d) Arrangements must be made for the transportation of the equipment in sufficient quantity and at the required times for the planned surgical lists.

- (ii) Arrangements for cleaning and sterilisation in the fundholder's surgery.

Where a decision is made not to "buy-in" sterile services certain requirements must be met. These must include:-

- (a) Collection
- (b) Cleaning and decontamination
- (c) Inspection and assembly
- (d) Sterilisation practices.

SECTION V - TECHNICAL SERVICES

- anaesthetic equipment

Modern anaesthetic machines and monitoring equipment are very sophisticated pieces of equipment which require skilled maintenance, frequent assessment, calibration and confirmation that they are functioning properly.

(i) Anaesthetic, resuscitation and monitoring equipment.

There must be in place arrangements to ensure that there is regular servicing of all anaesthetic, resuscitation and monitoring equipment. There should be regular training and assessment of staff who will be using this equipment in order to maintain their competence. In addition, the premises should also receive the appropriate Hazard Warnings issued by the Department of Health. Advice on how this can best be done is available from the Association of Anaesthetists document [16].

It is important when considering equipment to be aware of the responsibilities placed upon users by product liability.

(ii) Medical gases

In the absence of a fixed pipeline system, these are stored in cylinders. The storage and supply of medical gases must conform to the regulations in HTM 2022 [17].

(iii) Volatile anaesthetic agents

These must be stored and transferred to anaesthetic vaporisers in accordance with the manufacturer's instructions.

(iv) Waste anaesthetic agents

Arrangements must be made for the extraction of waste anaesthetic agents as recommended in HTM 2022.

SECTION VI - QUALITY, FINANCIAL AND CONTRACTUAL ARRANGEMENTS

Where procedures currently undertaken in hospitals are, in future, to be undertaken in practice premises, the quality of care of the patient must not be compromised by this shift. It is the responsibility of those commissioning such services to ensure that this is so.

It is important to point out that undertaking such activities in practice premises will affect overall funding and deployment of personnel. Such changes must not compromise the quality of the remaining services.

If surgeons or anaesthetists employed by a trust independently undertake work for a GP fundholder, whether in the GP fundholder's premises or in a private facility, the trust as an employer may regard this as unacceptable behaviour and take action against the individual consultants. Some trusts have introduced contracts for new consultants banning them from working privately on GP fundholders' patients, the so called "fidelity clause". Finally, a recent publication from the National Health Services (NHS) Executive indicates that all income from any separate contracts with any third party is deemed to be private practice. As such, it counts towards the 10% limit for full time consultants. Furthermore, this work is not covered by the NHS Indemnity Scheme and practitioners are strongly advised to ensure they have appropriate medical defence insurance cover [18].

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