# ‘Argent Provocateur’ …

The editor was interested to see that the new by-line of ‘Argent Provacateur’ has lived up to its expectation as a forum for discussion of resources in today’s cash-strapped NHS. He does, however, have some explaining to do.

Firstly, the title. It’s a pun on the Latin for silver, meaning money, not a typographical error.

Secondly, the content. Two articles in response have been received. He commends them to you, as they demonstrate the strengths and the future of the service.

Communication, even in these days of email and social media, remains a serious problem for the Trust. From clinical experience in a different context, senior clinical staff are tied up simply negotiating with doctors about appointments.

More interesting is the allegation that the largest clinical department in the hospital is not currently rostering its staff in sufficient time for effective decision making. Also suggested is that decision making of this kind remains an individual, rather than a corporate issue.

The decision to publish the original article was difficult and the subject matter sensitive and risky. What has been recognised is a case here for an organisational change which unifies Pre-operative Assessment and Anaesthesia and provides medical and administrative support – at a sufficiently senior level – for a joint venture. If this comes out of this series of correspondence, the risk will have been justified.

Correspondence remains open for all interested parties.

# Full blood count testing in pre-operative assessment clinics

Marion Wood, RGN

**Marion is the transfusion practitioner with University Hospitals of Morecambe Bay NHS Foundation Trust (UHMBFT), and was one of the original nurses to set up this service. Prior to this appointment, she worked as a pre-operative assessment nurse.**

In the last issue the editor challenged some of the concepts of pre-operative assessment. I was at the time carrying out a small audit looking at the Hb results of patients who visited the pre-operative clinic in a one-week period in December. This was to provide some data for a working group looking into the appropriate use of IV iron pre-operatively. Part of the audit was to find out whether the full blood count test had already been done by the general practitioner (GP) prior to the pre-operative assessment appointment and whether the results of that, or the test taken at the pre-operative assessment clinic, were reviewed.

## GUIDELINES

- The NICE guidelines on pre-operative testing suggest that a full blood count should be considered for all types of surgery in patients over the age of 60.[1] It should also be done in all adult patients undergoing major surgery
- The British Committee for Standards in Haematology (BCSH) guidelines for the clinical use of red cell transfusions states that the objective in patients undergoing surgery should be to manage the patient so that they do not need a red cell transfusion.[2] Part of this management should be to investigate and treat anaemia prior to the surgery

## METHOD

Patients who attended the pre-operative assessment clinic in the week commencing 10 December were included in the audit. This week was chosen as pathology had stopped sending out paper reports, so therefore it was possible to check who had viewed the results on the two computerised records, Indigo and Lorenzo.

## RESULTS

A total of 242 patients attended pre-operative assessment (POA) during the week.

| Hospital | RLI | WGH | FGH |
|---|---|---|---|
| Attended POA | 98 | 54 | 90 |
| FBC (full blood count) | 71 | 49 | 82 |
| Results reviewed | 68 | 49 | 80 |
| FBC not taken at clinic | 27 | 5 | 8 |
| FBC taken prior to POA | 12 | 3 | 5 |
| Result reviewed by POA | 7 | 3 | 3 |

Seventy-nine per cent of patients were shown to have the test carried out following NICE guidelines. However, the depth of the audit does not allow confirmation of whether the remaining 21% were tested as indicated by type of surgery and comorbidity. There were only five results, from a test taken at the clinic, that were not reviewed by the pre-operative

nurse, and at least one of these was because the patient postponed the surgery.

The pre-operative nurses also review 65% of the full blood count tests taken prior to the clinic.

## CONCLUSIONS

The pre-operative assessment clinics 'does what it says on the tin', and allows for assessment of the patients pre-operatively. The results are reviewed by the pre-operative nurses in a timely manner and further investigations may then be commenced. The pre-operative nurses work in a difficult role trying to meet the expectations of several different groups:

- The surgeon who often has not had the time to assess the overall fitness of the patient but wants to get the surgery done
- The anaesthetic team, a group of individuals with different standards for acceptance of patients. It is often unclear as to who is going to anaesthetise until the week of surgery and then they are difficult to meet to discuss the case due to other commitments
- The waiting list team who need to fill the operating lists and meet the government targets
- The most important is the individual patient with all their anxieties and expectations about their forthcoming surgery

**It is a role where the stresses and challenges are not always fully appreciated by other clinicians, managers or even editors of journals!**

It is surprising that only 8.26% of these patients had a full blood count done in the previous five months despite having been referred to the hospital for a condition that may require surgery. There is an opportunity for GPs to check the full blood count following the NICE guidance prior to referring patients for surgical procedures. This would allow anyone with low haemoglobin to be investigated and treated in a timelier manner, as suggested by the NICE guidelines. Perhaps when primary care takes on further responsibilities in the provision of health services, the pre-assessment clinics would be run at the local health centre nearer to the patient's home.

## REFERENCES

1. National Institute for Clinical Excellence. Clinical Guidelines 3 –Pre-operative tests. London: National Institute for Clinical Excellence; 2003

2. British Committee for Standards in Haematology. Guidelines for the Clinical Use of Red Cell Blood Transfusion. Br J Haematol 2001;113: 24-31

I would like to respond to the editor's thought-provoking article about pre-operative assessment. Prior to August 2010 I had regular anaesthetic sessions within our trust. Since a road traffic collision in 2010 I have also become an avid consumer of NHS healthcare. I would, therefore, like to share my personal experience as a patient regarding pre-operative assessment clinics. I was referred to two separate hospitals in the greater Manchester region for further surgery, both on a day-case basis with overnight stay. For both procedures, that were booked and discussed by the surgeon in outpatients, I received appointments for pre-operative assessment clinics – with regards to these clinics all the trusts seem to be 'at it'. Although I was dealt with in an efficient and professional way at each separate appointment, I failed to see the necessity of having to spend the best of the day waiting for routine tests and filling in health questionnaires when all the information required is already available. At the time of these appointments I was still wheelchair-bound and in quite considerable discomfort from my injuries. Both appointments required me to spend three hours as a passenger in a car and my long-suffering partner having to take a day off work (I dread to think how disruptive it must be for an elderly, poorly mobile patient from Sedbergh having to make his way to the hospital to attend pre-op assessment). All information gained at these appointments could have been obtained from a brief telephone call to my GP (or by perusal of a powerful IT package?) and by me filling in a questionnaire in the comfort of my own home.

So the question remains: who benefits? In my case neither the patient nor primary care who end up paying twice for redundant information. How about the secondary care trusts, then? Was my attendance at these clinics vital in order to prevent my surgery to be cancelled on the day unnecessarily? An approach that focuses on pre-optimising patients with easily identifiable pre-operative risks as alluded to in the editor's article appears to be worthwhile pursuing and excellent value for money. The setup for such a service already exists within our trust!

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