Служба анестезії та болю в Великобританії: акцент на гайдлайни

Dr Roman Cregg MB BS FRCA FFPMRCA PhD
Consultant and Hon Associate Professor,
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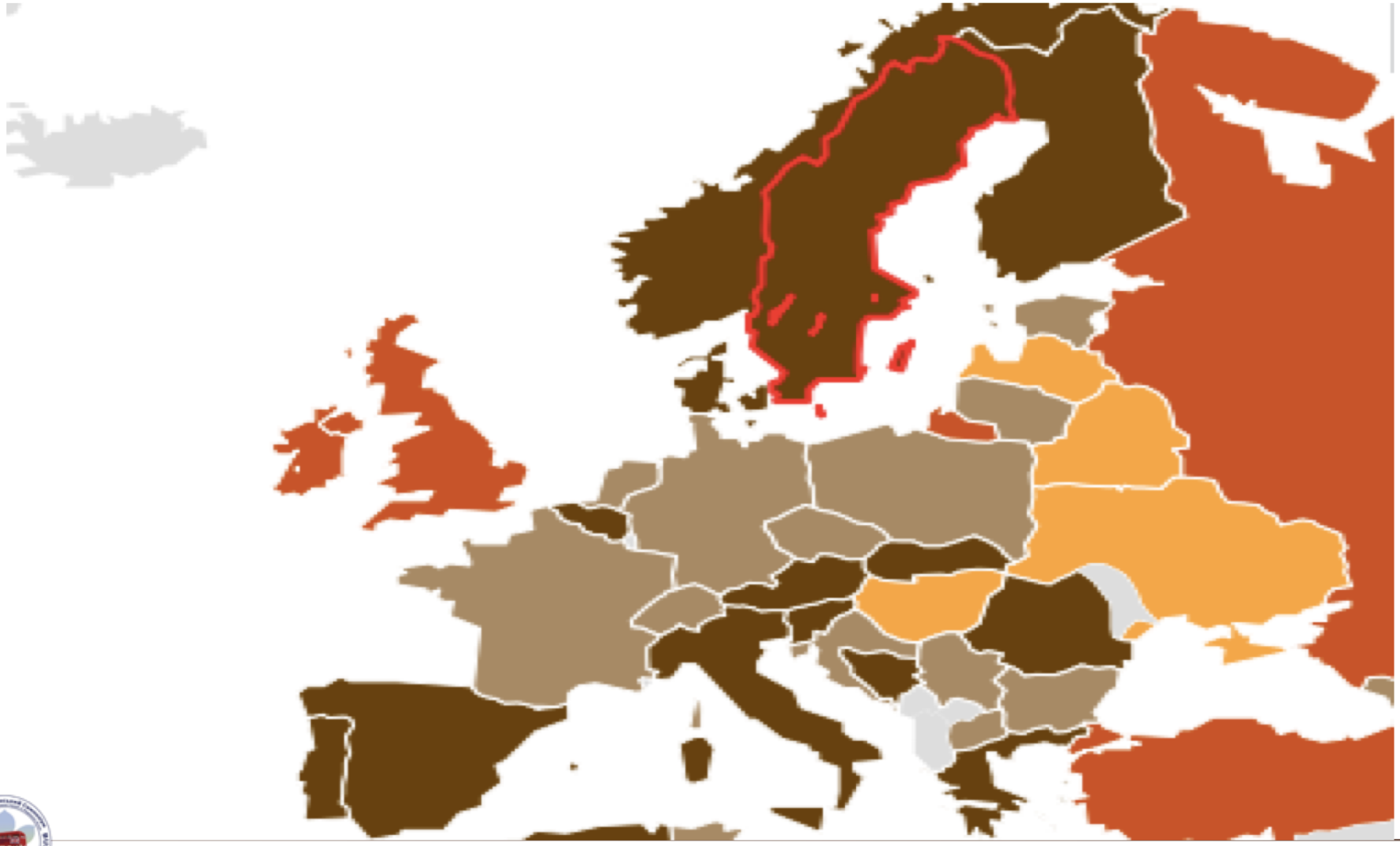
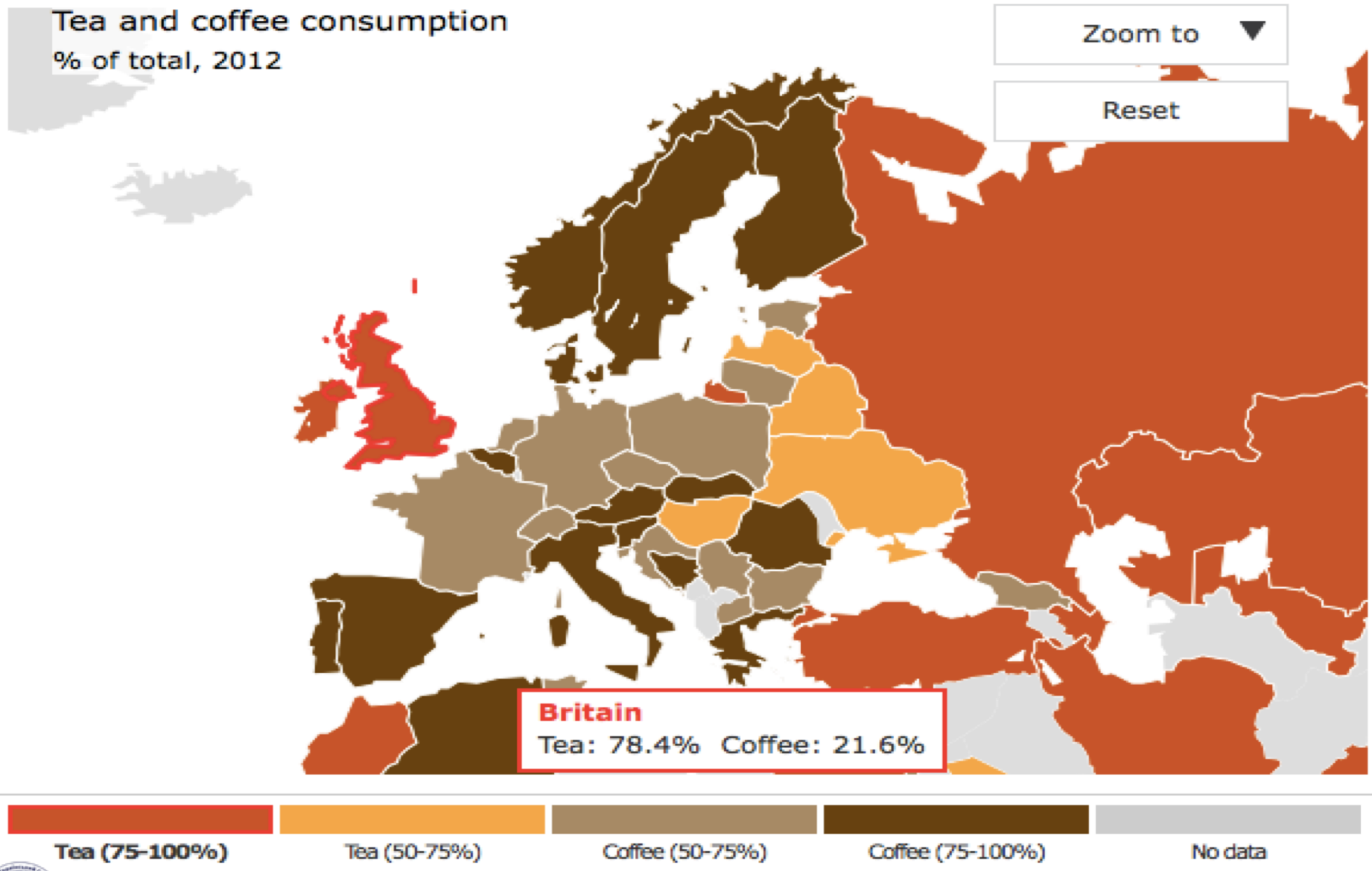
Brexit



Tea or coffee



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Визначення

Клінічна настанова або **Клінічна настанова з кращої практики** документ:

- полегшити прийняття рішень
- визначення критеріїв діагностики
- ведення і лікування у конкретних галузях охорони здоров'я.

Сучасні медичні настанови засновані на аналізі наявних даних у межах концепції доказової медицини.

Працівник охорони здоров'я зобов'язаний знати медичні настанови по своїй професії та повинен вирішити, чи потрібно слідувати рекомендаціям настанов для лікування конкретного пацієнта.

На основі клінічних настанов розробляються **стандарти лікування** та **клінічні протоколи** лікування.

Потім на основі останніх розробляються локальні протоколи певного лікувального закладу (із врахуванням особливостей забезпечення)

Calendar of Events

April

M	T	W	T	F	S	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Guidelines

- Guidelines for the Provision of Anaesthesia Services for an Obstetric Population 2019
- Guidelines for the Provision of Anaesthesia Services for Burn and Plastics Surgery 2019
- Guidelines for the Provision of Anaesthesia Services for Day Surgery 2019
- Guidelines for the Provision of Anaesthesia Services for ENT, Oral Maxillofacial and Dental surgery 2019
- Guidelines for the Provision of Anaesthesia Services for Inpatient Pain Management 2019
- Guidelines for the Provision of Anaesthesia Services for Intraoperative Care 2019
- Guidelines for the Provision of Anaesthesia Services for Preoperative Assessment and Preparation 2019
- Guidelines for the Provision of Anaesthesia Services for Trauma and Orthopaedic Surgery 2019
- Guidelines for the Provision of Anaesthesia Services in the Non-theatre Environment 2019
- Guidelines for the Provision of Emergency Anaesthesia 2019

Royal College of Anaesthetists

Chapter 5

Guidelines for the Provision of Anaesthesia Services (GPAS)

Guidelines for the Provision of Emergency Anaesthesia 2019

Chapter 5
Guidelines for the Provision of Emergency Anaesthesia Services 2019

Aims and objectives

The objective of this chapter is to promote current best practice for service provision in emergency anaesthesia. The guidance is intended for use by anaesthetists with responsibilities for service delivery and healthcare managers.

This guideline does not comprehensively describe clinical best practice in emergency anaesthesia, but is primarily concerned with the requirements for the provision of a safe, effective, well led service, which may be delivered by many different acceptable models. The guidance on provision of emergency anaesthesia applies to all settings where this is undertaken, regardless of funding. All age groups are included within the guidance unless otherwise stated, reflecting the broad nature of this service.

A wide range of evidence has been rigorously reviewed during the production of this chapter, including recommendations from peer reviewed publications and national guidance where available. However, both the authors and the CDG agreed that there is a paucity of Level 1 evidence relating to service provision in head and neck anaesthesia. In some cases, it has been necessary to include recommendations of good practice based on the clinical experience of the CDG. We hope that this document will act as a stimulus to future research.

The recommendations in this chapter will support the RCoA's Anaesthesia Clinical Services Accreditation (ACSA) process.

Medicolegal implications of GPAS guidelines

GPAS guidelines are not intended to be construed or to serve as a standard of clinical care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is advised, however, that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

Areas included are:

- levels of provision of service, including (but not restricted to) staffing, equipment, support services and facilities
- areas of special requirement, such as paediatrics and elderly care
- training and education
- research and audit
- organisation and administration
- patient Information

Emergency aspects of paediatric anaesthesia are dealt with in more detail in chapter 10. These guidelines do not include obstetrics or major trauma, which are dealt with separately in chapter 9 and chapter 16.

Anaesthesia team and theatre staff

1.1 Hospitals admitting emergency surgical patients should provide, at all times, a dedicated, fully staffed, operating theatre appropriate to the clinical workload that they accept. There should be provision to increase resources if necessary to manage fluctuating work load demands and still provide an acceptable standard of care.[13,33,42]

1.2 At all times, there should be an on site anaesthetist who has the ability and training to undertake immediate clinical care of all emergency surgical patients. Explicit arrangements should be in place to provide support from additional anaesthetists appropriate to local circumstances.

1.3 The emergency anaesthesia team should be led by a consultant anaesthetist and include all medical and other healthcare professionals involved in the delivery of anaesthesia for emergency surgery.[13,43] Part of this role should include liaison with other departments such as radiology, medicine and emergency departments (ED).

1.4 All patients should have a named and documented supervisory consultant anaesthetist who has overall responsibility for the care of the patient.[44,45] A suitably trained and experienced staff grade, associate specialist and specialty (SAS) doctor could be the named anaesthetist on the anaesthetic record if local governance arrangements have agreed in advance that the individual doctor can take responsibility for patients in the particular circumstances, without consultant supervision.

1.5 The level of staffing should be sufficient for the consultant leading the emergency anaesthesia team to be able to provide a continuous emergency anaesthesia service in the theatre complex without interruption. Other service requirements, e.g. remote sites, trauma calls and advice should be anticipated and managed through local arrangements.[25] Anaesthetists assigned to provide cover for emergency lists should not also be assigned to elective work; neither should anaesthetists be assigned to undertake emergency work while also assigned to supporting professional activities(SPA).[46]

What is the level of evidence?

An individual simply 'doing his or her best' is no longer enough. Evidence based pathways and quality improvement programmes need to be implemented. Within this, individuals can still strive for excellence, but as part of a whole team.[14,28,29,30,31]

To enable patients to receive high quality emergency anaesthesia, local and national supporting services and facilities are required. Of particular importance is timely access to critical care, radiology and operating theatres.[1,3,9,32,33]

Supporting clinical policies need to be in place, including preoperative assessment, management of severe sepsis and postoperative care.[1,9,14,34]

The Royal College of Anaesthetists has been developing the concept of the anaesthetist as the perioperative physician. Emergency anaesthesia is one of the areas where the skills of the anaesthetist can be used in this role.[35]

Key to the delivery of a high quality emergency anaesthesia service is adequate resourcing and finance.[36,37,38,39]

Recommendations

The grade of evidence and the overall strength of each recommendation are tabulated in Appendix 1.

3.34	C	Strong
3.35	M	Mandatory
3.36	C	Strong
3.37	C	Strong
4.1	C	Strong
4.2	C	Strong
4.3	C	Strong
4.4	C	Strong
4.5	C	Strong
4.6	C	Strong
4.7	C	Strong
4.8	C	Strong
4.9	C	Strong
4.10	C	Strong
4.11	C	Strong
4.12	C	Weak
5.1	C	Strong
5.2	GPP	Strong
5.3	C	Strong
5.4	C	Strong
5.5	M	Mandatory
5.6	M	Mandatory
5.7	M	Mandatory
5.8	C	Strong
5.9	M	Mandatory
5.10	C	Strong
5.11	C	Strong
5.12	C	Strong

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9 Patient Information

The basic principles of information and consent that apply to elective patients also apply to emergency patients. Both have been the subject of recent legal rulings emphasising patient autonomy, the concept of the reasonable patient, material risk and rejecting medical paternalism.[215] For emergency patients, there are additional considerations that may make this process more complex and difficult to deliver. These include patient factors (fear, pain, analgesic drugs, pre-existing comorbidities and frailty), disease (uncertainty of diagnosis and prognosis) and situational factors (speed of decision making, multiple medical inputs, and uncertainty of critical care requirements). These additional issues should be understood, and taken into account when an emergency patient is given information or consent is sought. This is particularly true in vulnerable patients i.e. patients with learning disabilities, dementia and communication difficulties.

Evidence of the efficacy and feasibility of delivery of these principles for emergency anaesthesia is limited.

9.1 Organisations should provide up to date, reliable information resources for patients and their relatives e.g. based on literature available from the Royal College of Anaesthetists and Association of Anaesthetists.[216] It should include information about the process they will experience, and what their postoperative care will mean for them.[217,218]

9.2 As part of a quality improvement programme, hospitals should develop a local understanding of the adequacy of their consent process and information supplied to patients undergoing emergency surgery, by proactively seeking patient feedback and allocating appropriate resources to this process.[204]

9.3 Organisations should have clear guidance, policies and training for all staff taking consent, which is in accordance with GMC guidance. Anaesthetists must work in partnership with patients and other healthcare professionals, to ensure good care guided by the principles listed next.[219]

- Healthcare professionals should assume patients have capacity to make decisions until assessed and proven otherwise. Clinicians should support patient autonomy in reaching

Recommendations for local audit

- Scheduled reports e.g. National Confidential Enquiry into Patient Outcome and Death (NCEPOD), National Emergency Laparotomy Audit (NELA)
- Participation in local and national audit of risk-adjusted mortality and morbidity
- Variation in work patterns, resource allocation, efficiency, systems of care

NICE National Institute for Health and Care Excellence

Dr Françoise Cluzeau, Associate Director, NICE International
Dr Ryan Li, Adviser, NICE International

NICE: what is it ?

The National Institute for Health & Care Excellence (NICE) is the independent organisation responsible for providing national guidance and advice to improve health and social care

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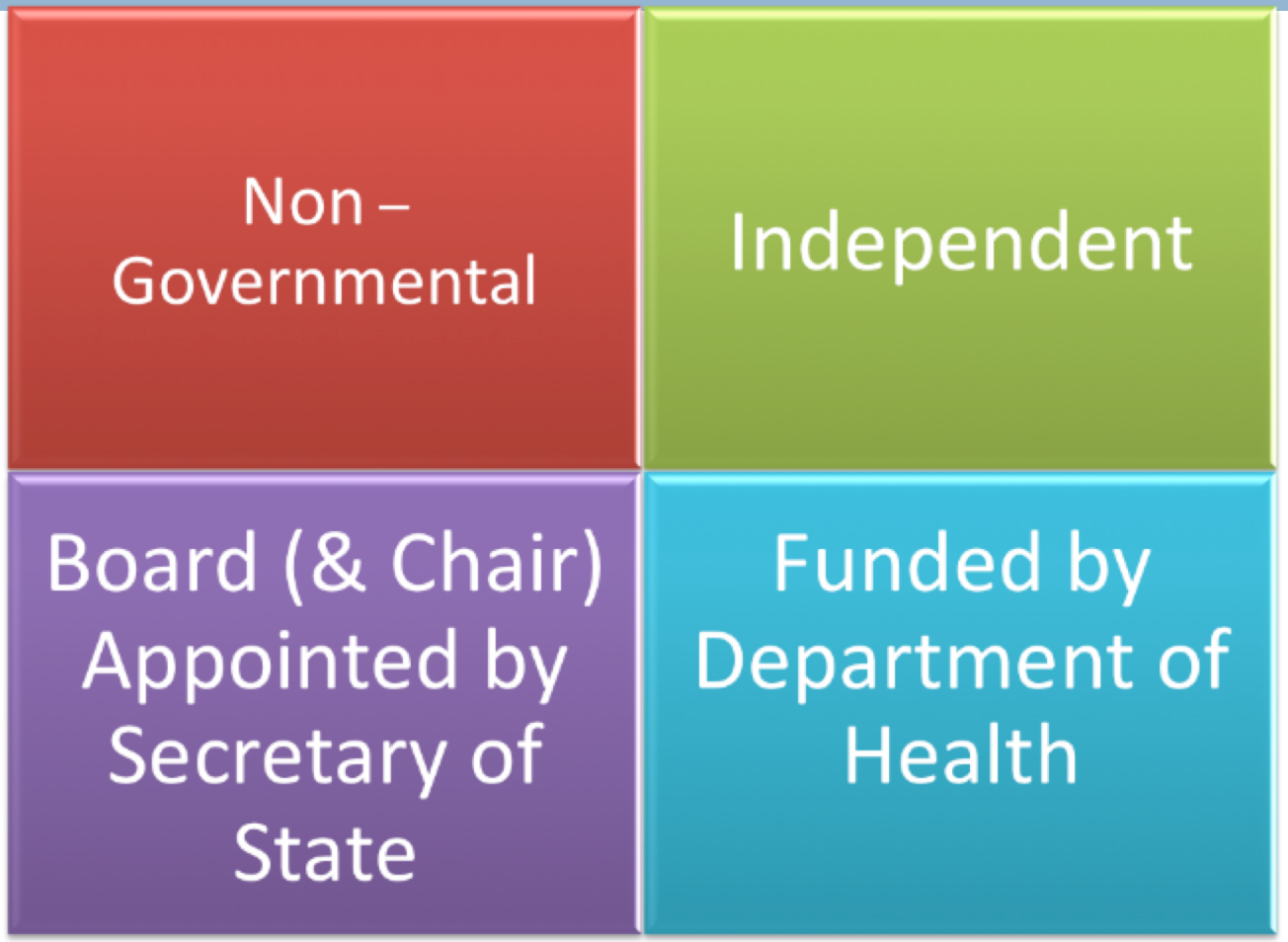
NICE as an organisation



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Roles of NICE

To reduce variation in the availability and quality of treatments and care

Help resolve uncertainty about which medicines and treatments work best and which represent best value for money for the NHS

Set national standards on how people with certain conditions should be treated

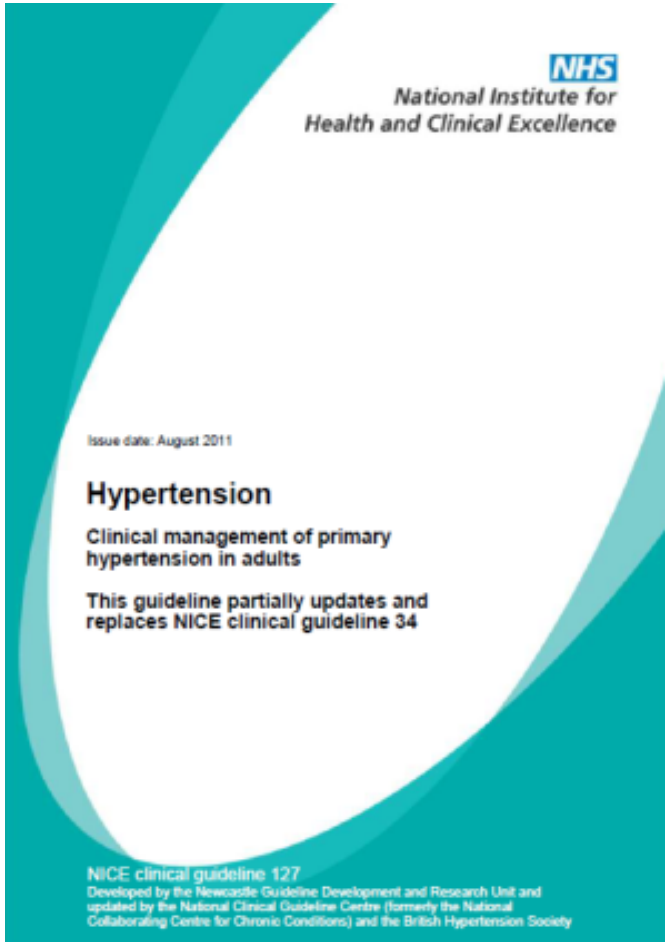
Dr Françoise Cluzeau, Associate Director, NICE International
Dr Ryan Li, Adviser, NICE International

Why NICE clinical guidelines and quality standards?

- **Variation in care and health outcomes** across the country – *"postcode lottery"*
  - "Different organisations set different standards, using different methods [and] evidence… not clear which standards must be followed and which are optional" *Sir Liam Donaldson, previous Chief Medical Officer*
- NICE given responsibility to develop guidance:
  - To promote **cost-effective use of NHS resources**
  - Based on **best available evidence** and **participatory process**

What are NICE Clinical Guidelines?

- Broad guidance covering management of a particular condition
- Considers **clinical and cost-effectiveness**, and **patient/carer perspective**
- Incorporates other relevant NICE guidance (e.g. Technology Appraisals for specific drugs)
- **Recommendations** are advisory, not mandatory… *but can be used to develop* ***quality standards***



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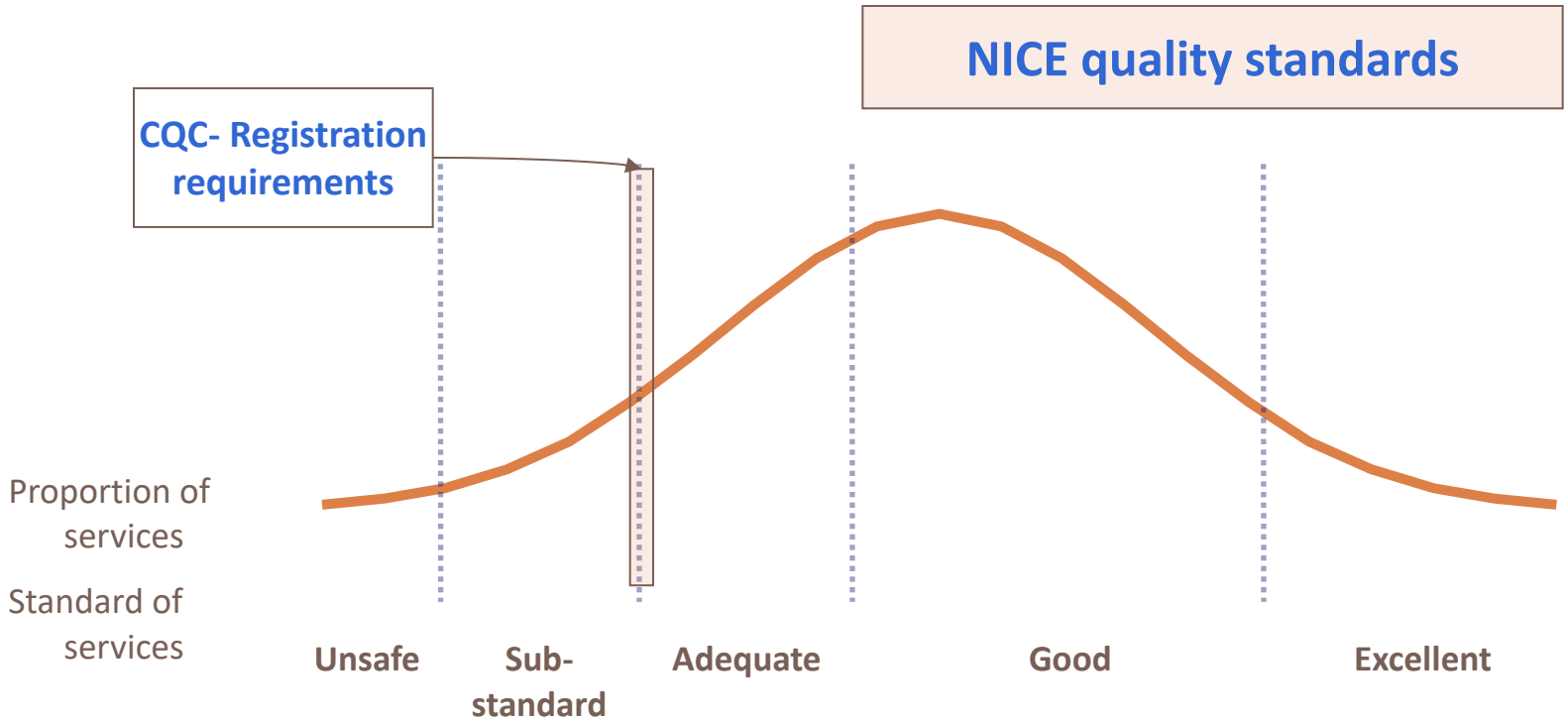
NICE quality standards define *best practice*, not minimum standards



Quality standards complement regulatory or other minimum requirements

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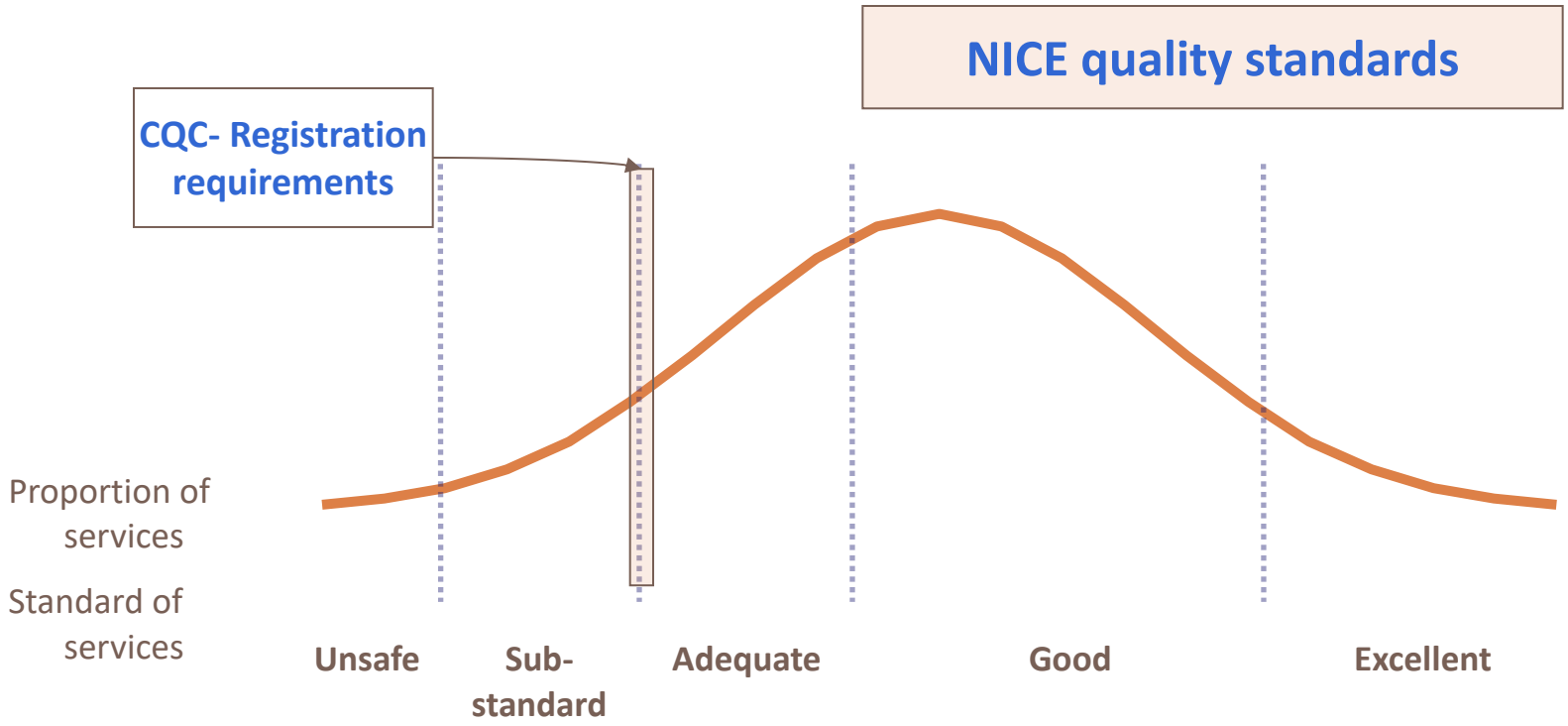

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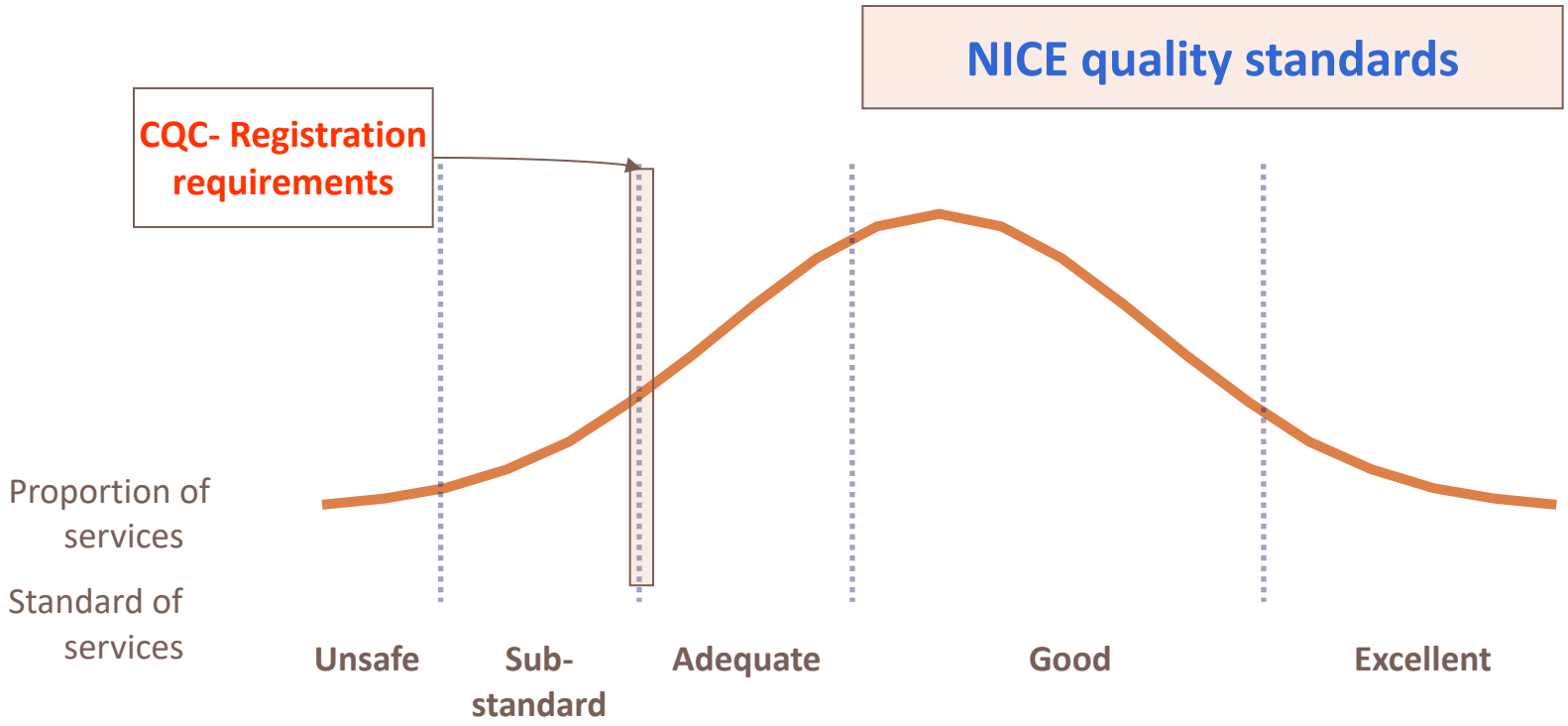

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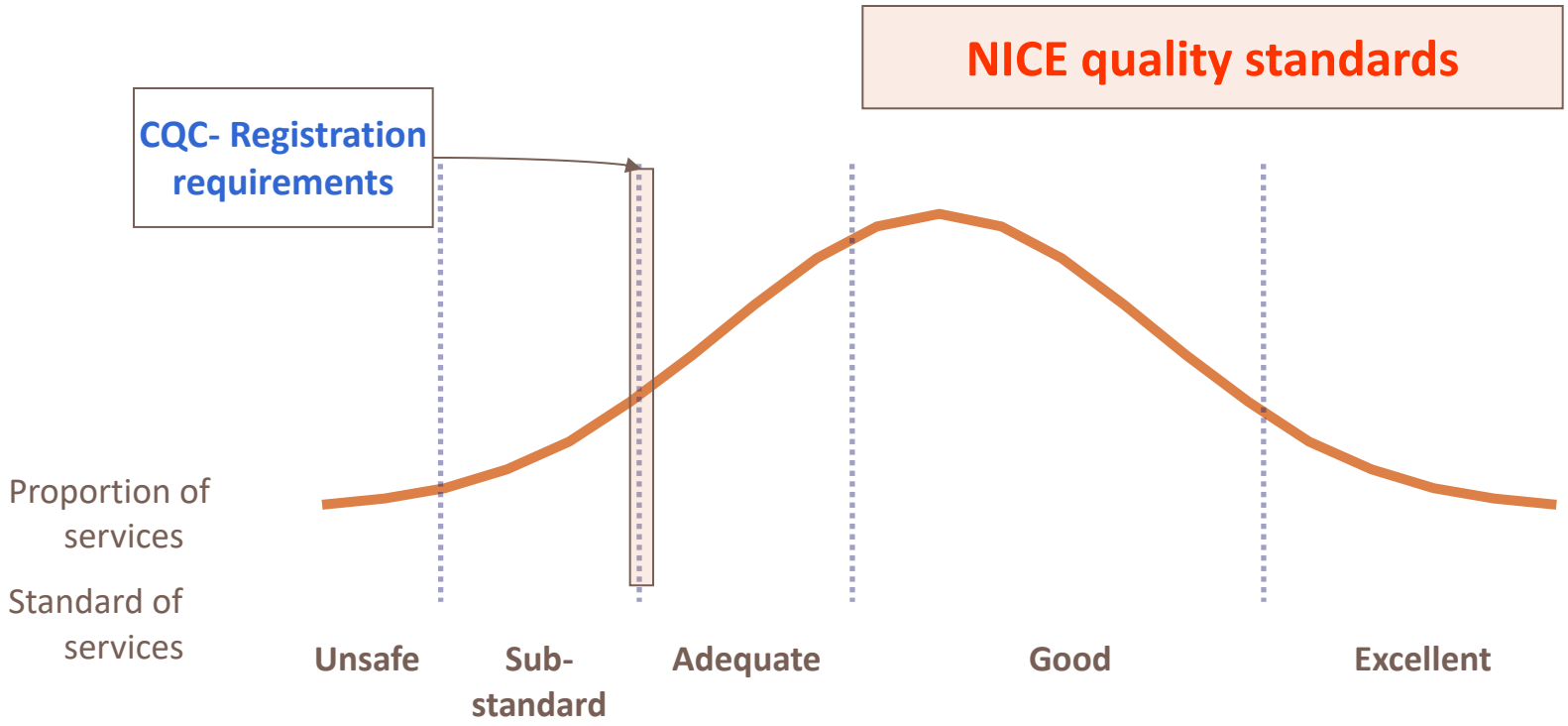

Quality standards complement regulatory or other minimum requirements

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Best practice, Versus minimum standards

- AAGBI requirements

Versus

- Best practice for general anaesthesia

Medicolegal implications

Medicolegal implications of GPAS guidelines

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Example: Quality standard for stroke developed from NICE guideline

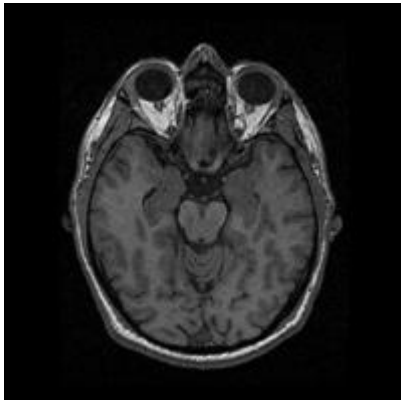
NICE clinical guideline recommendation (2008)

Brain imaging should be performed immediately* for people with acute stroke if any of the [indications] apply.

*'Immediately' is defined as 'ideally the next slot and definitely within 1 hour, whichever is sooner'

Quality standard (NICE 2010)

Patients with acute stroke receive brain imaging within 1 hour of admission if they meet any of the indications for immediate imaging.



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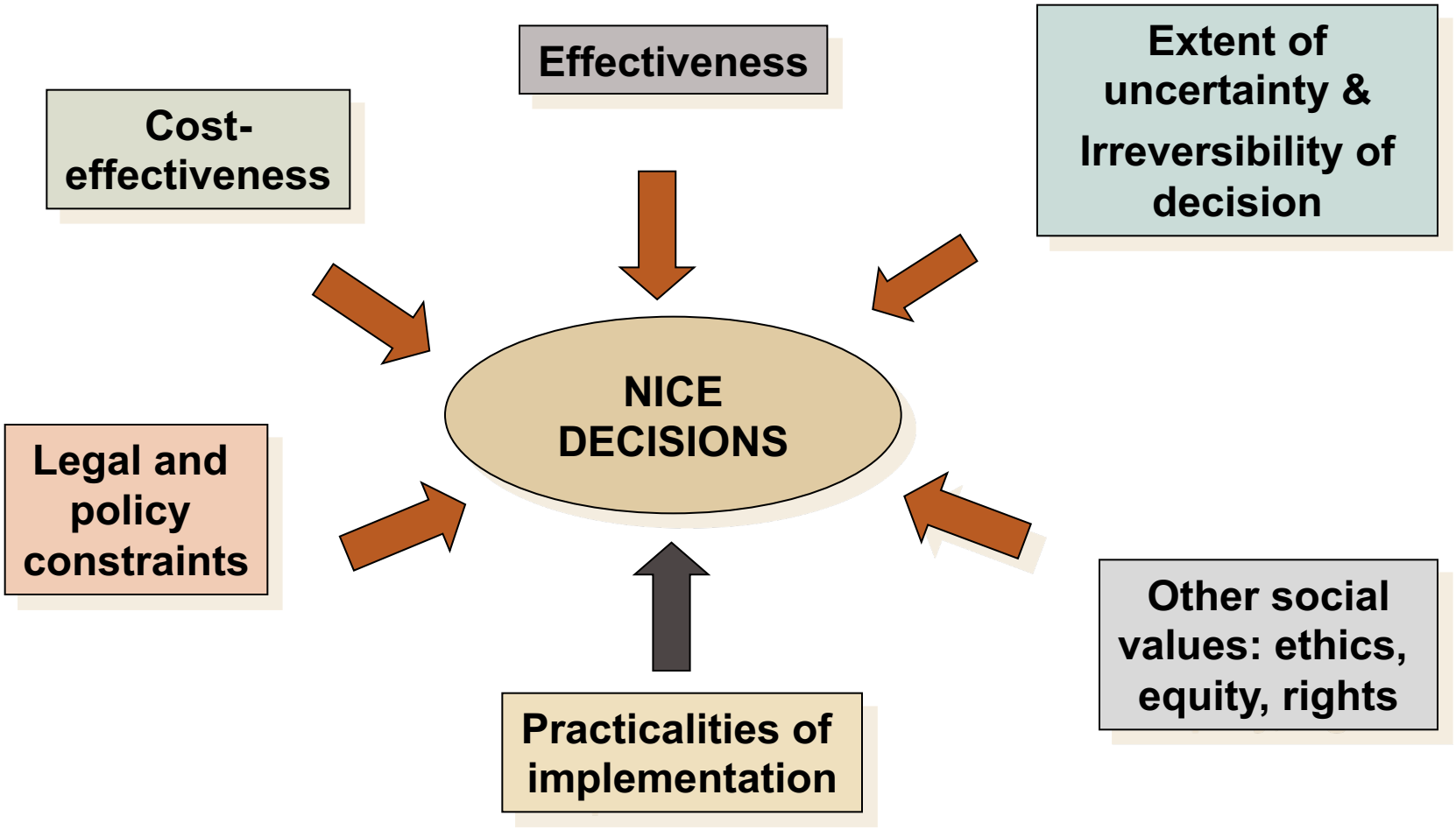
Key role is to make judgements based on the evidence



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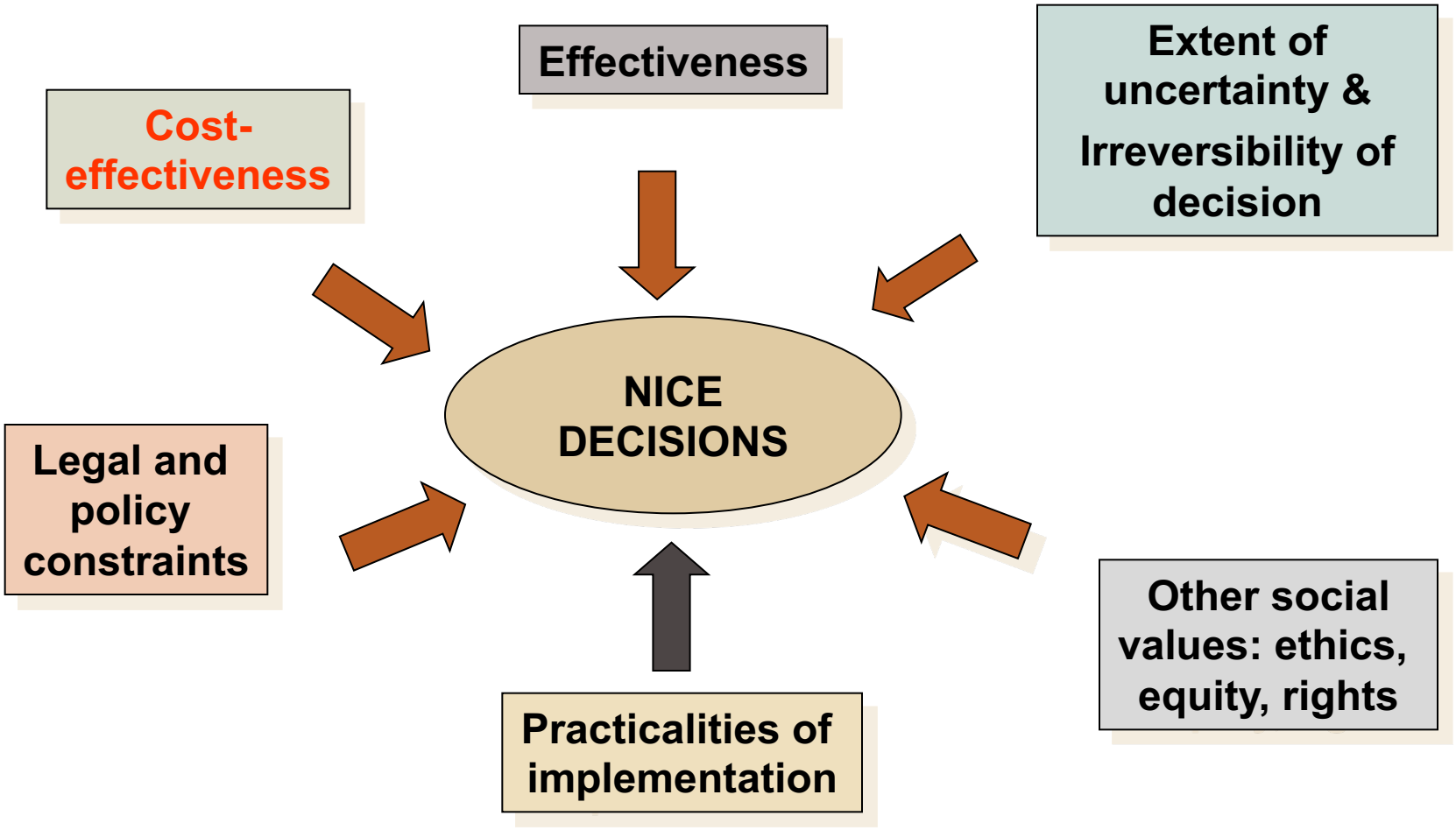
Key role of the GDG is to make judgements based on the evidence



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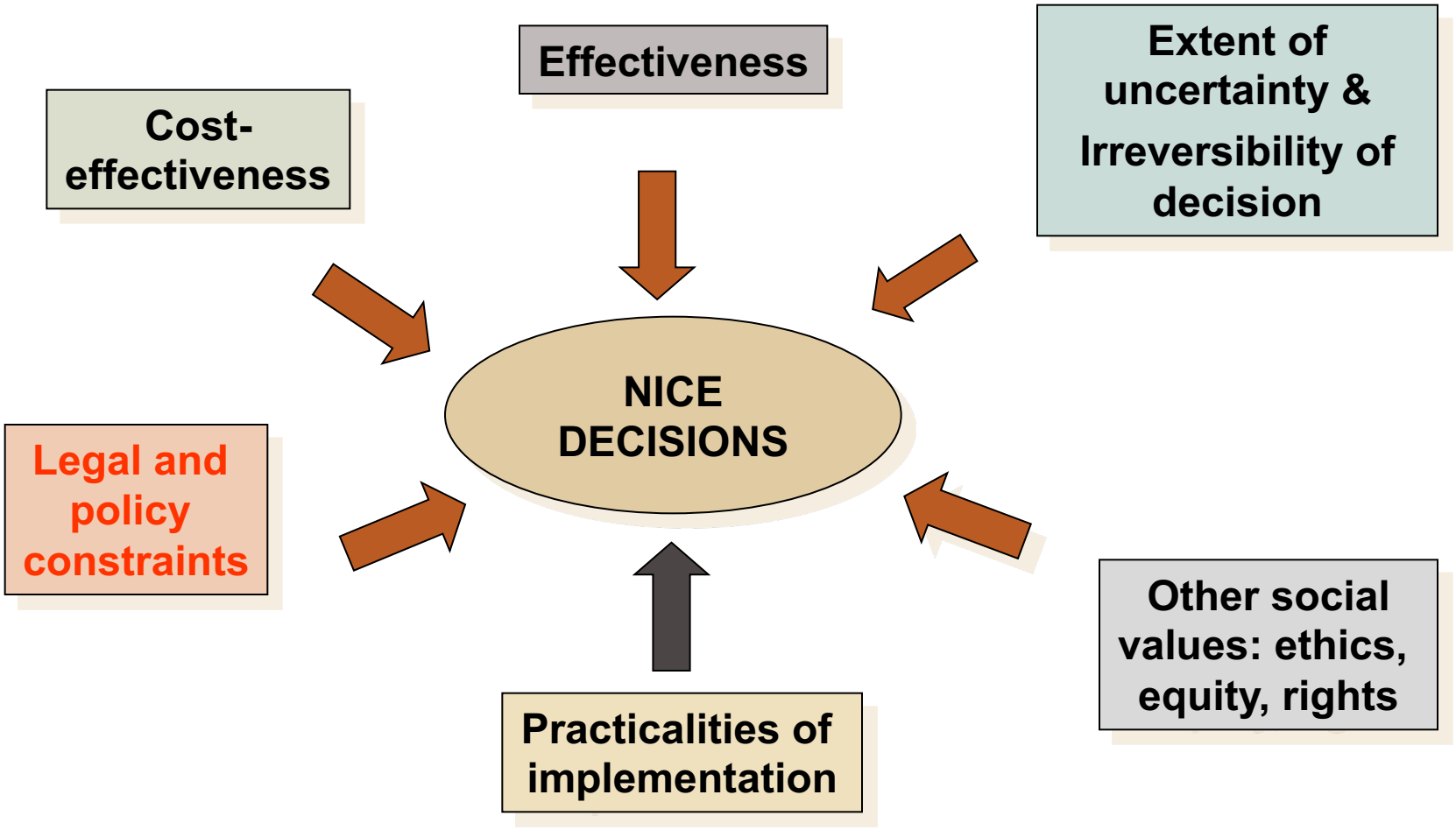

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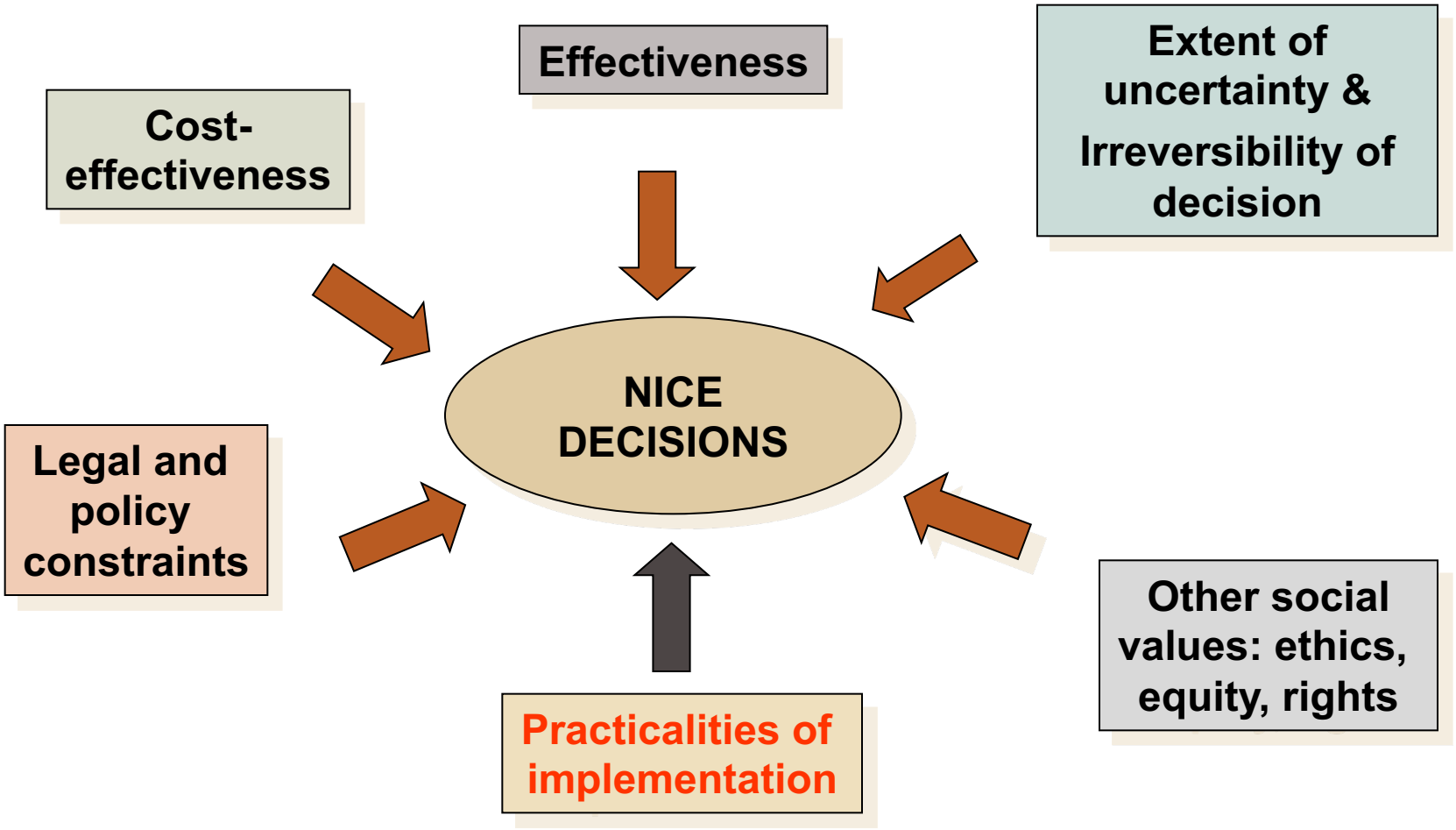

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Cost Impact Statement

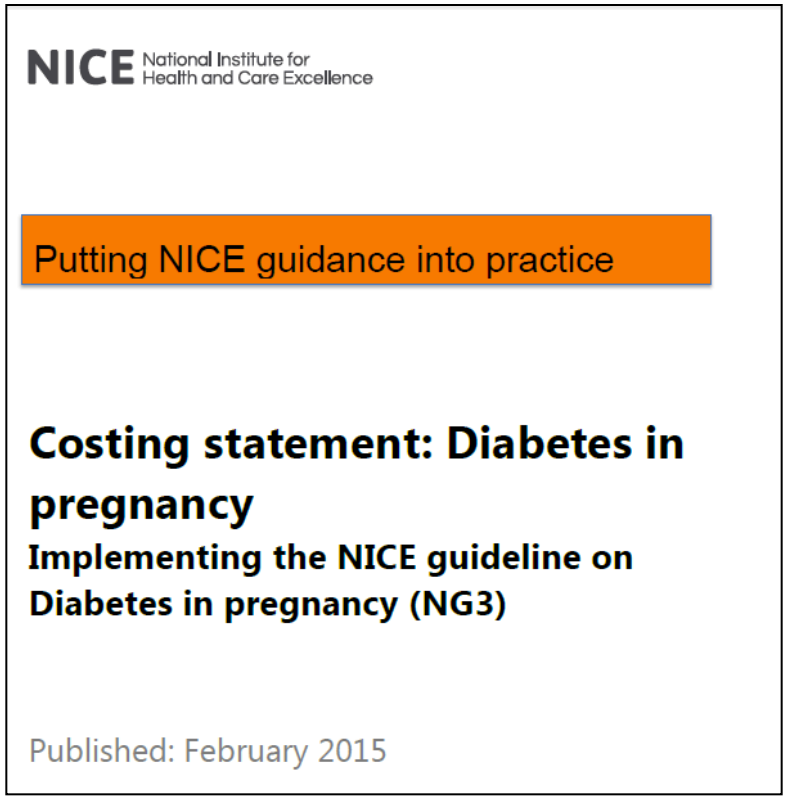
***Advise pregnant women with type 2 diabetes or gestational diabetes who are on a multiple daily insulin injection regimen to test their fasting, pre-meal, 1-hour post-meal and bedtime blood glucose levels daily during pregnancy*. (recommendation 1.3.2)**

Expert clinical opinion: recommendation could potentially double the number of testing strips being used by pregnant women with type 2 or gestational diabetes

box of 50 testing strips costs £2.29 (NHS electronic Drug Tariff). Expert clinical opinion suggests approximately 80% to 90% (1,400) of women with type 2 diabetes and 20% (5,600) of women with gestational diabetes are on a multiple daily insulin injection regimen

Table 1 Maximum cost impact of recommendation 1.3.2

Diabetes type	Pregnancies	Current boxes of strips used	Future boxes of strips used	Increased boxes of strips	Cost impact (£)
Type 2 diabetes	1,400	11,800	23,500	11,800	26,900
Gestational diabetes	5,600	47,000	94,100	47,000	107,700
Total (£)					134,600



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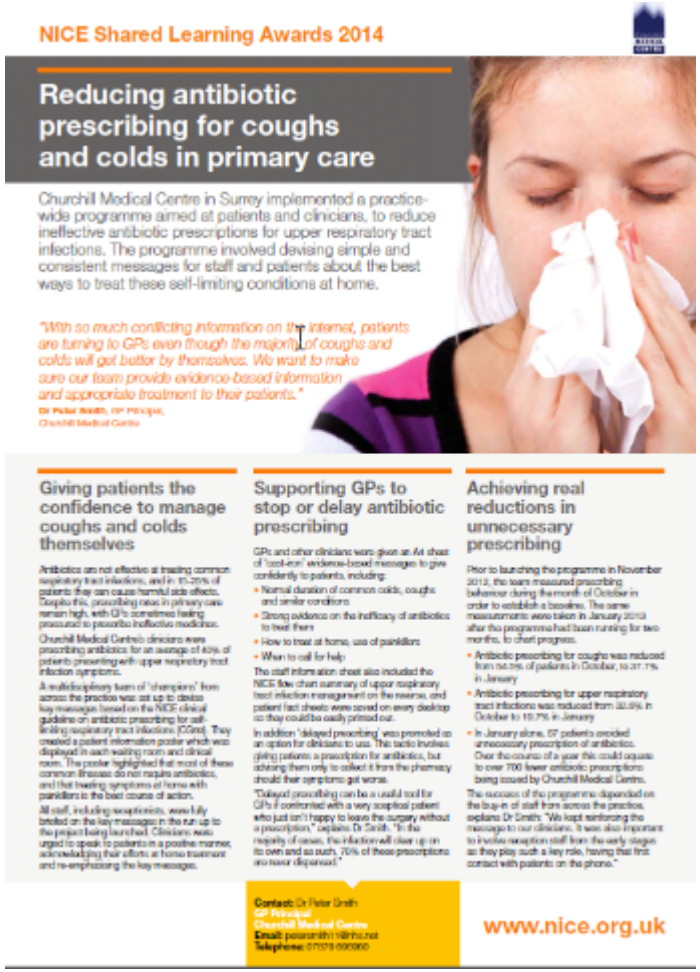
Local Practice improvement case studies shared learning



NICE Shared Learning Awards 2014

Reducing antibiotic prescribing for coughs and colds in primary care

Churchill Medical Centre in Surrey implemented a practice-wide programme aimed at patients and clinicians, to reduce ineffective antibiotic prescriptions for upper respiratory tract infections. The programme involved devising simple and consistent messages for staff and patients about the best ways to treat these self-limiting conditions at home.

"With so much conflicting information on the internet, patients are turning to GPs even though the majority of coughs and colds will get better by themselves. We want to make sure our team provide evidence-based information and appropriate treatment to their patients."

Giving patients the confidence to manage coughs and colds themselves

Antibiotics are not effective at treating common respiratory tract infections, and in 10-20% of patients they can cause harmful side effects. Despite this, prescribing rates in primary care remain high, with GPs sometimes feeling pressured to prescribe ineffective medicines.

Churchill Medical Centre's clinicians were prescribing antibiotics for an average of 40% of patients presenting with upper respiratory tract infection symptoms.

A multidisciplinary team of 'champions' from across the practice was set up to devise key messages, based on the NICE clinical guideline on antibiotic prescribing for self-limiting respiratory tract infections (CG69). They created a patient information poster which was displayed in each waiting room and clinical room. The poster highlighted that most of these common illnesses do not require antibiotics, and that treating symptoms at home with painkillers is the best course of action.

All staff, including receptionists, were fully briefed on the key messages in the run up to the project being launched. Clinicians were urged to speak to patients in a positive manner, acknowledging their efforts at home treatment and re-emphasising the key messages.

Supporting GPs to stop or delay antibiotic prescribing

GPs and other clinicians were given an A4 sheet of "cast-iron" evidence-based messages to give confidently to patients, including:

- Normal duration of common colds, coughs and similar conditions
- Strong evidence on the inefficacy of antibiotics to treat them
- How to treat at home, use of painkillers
- When to call for help

The staff information sheet also included the NICE flow chart summary of upper respiratory tract infection management on the reverse, and patient fact sheets were saved on every desktop so they could be easily printed out.

In addition 'delayed prescribing' was promoted as an option for clinicians to use. This tactic involves giving patients a prescription for antibiotics, but advising them only to collect it from the pharmacy should their symptoms get worse.

"Delayed prescribing can be a useful tool for GPs if confronted with a very sceptical patient who just isn't happy to leave the surgery without a prescription," explains Dr Smith. "In the majority of cases, the infection will clear up on its own and as such, 70% of these prescriptions are never dispensed."

Achieving real reductions in unnecessary prescribing

Prior to launching the programme in November 2012, the team measured prescribing behaviour during the month of October in order to establish a baseline. The same measurements were taken in January 2013 after the programme had been running for two months, to chart progress.

- Antibiotic prescribing for coughs was reduced from 54.5% of patients in October, to 37.7% in January
- Antibiotic prescribing for upper respiratory tract infections was reduced from 32.6% in October to 19.7% in January
- In January alone, 67 patients avoided unnecessary prescription of antibiotics. Over the course of a year this could equate to over 700 fewer antibiotic prescriptions being issued by Churchill Medical Centre.

The success of the programme depended on the buy-in of staff from across the practice, explains Dr Smith. "We kept reinforcing the message to our clinicians. It was also important to involve reception staff from the early stages as they play such a key role, having that first contact with patients on the phone."

Contact: Dr Peter Smith
GP Partner
Churchill Medical Centre
Email: psmith@nhs.net
Telephone: 01372 000000

www.nice.org.uk

- Antibiotic prescribing for coughs reduced from 54.5% to 37.7% over 3 months
- Antibiotic prescribing for URTI reduced from 32.6% to 19.7% over 3 months
- In January alone, 67 patients avoided unnecessary prescription of antibiotics (over 700 fewer prescriptions in 1 year)

Lessons

- Buy-in of staff from across the practice
- reinforcing the message to clinicians
- Involving reception staff from the early stages as first contact with patients on the phone.

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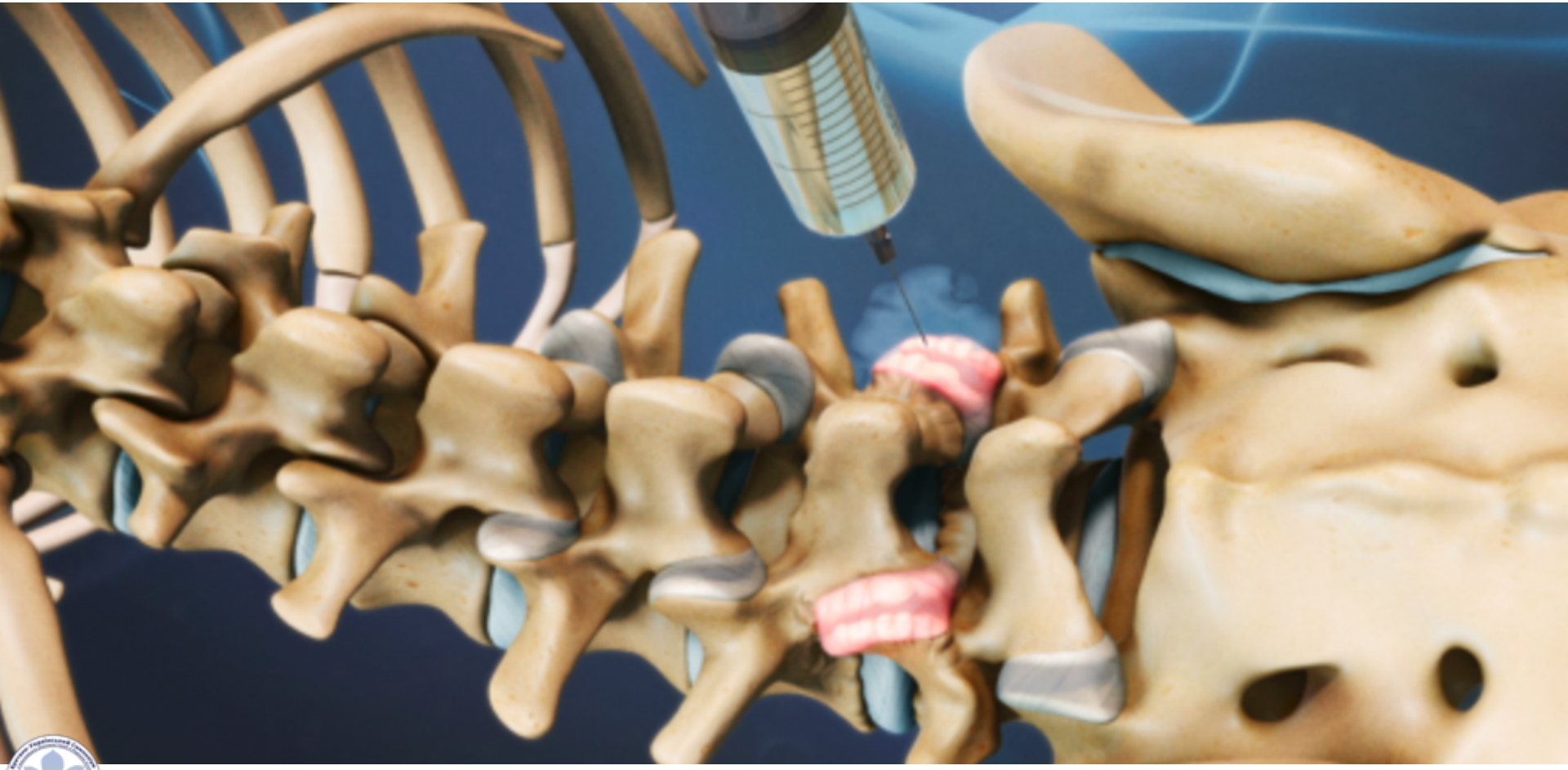
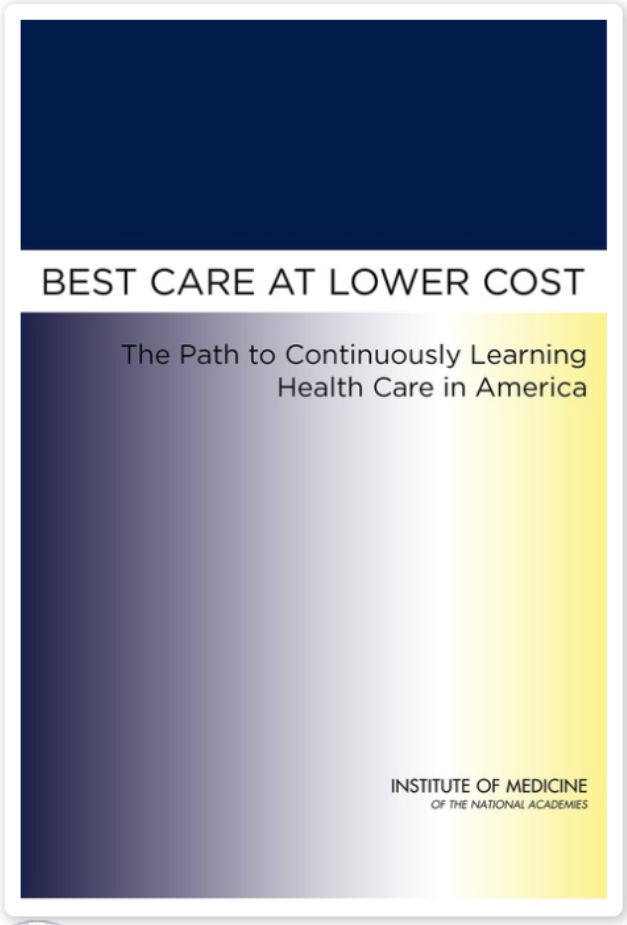
NHS / Private Practice / NICE





Best Care at Lower Cost

The Path to Continuously Learning Health Care in America (2013)

Consensus Study Report

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What is an Ebook?

Literature assessment:

Table: Assessing different forms of literature that can be used by health systems.

	Efficient Form of Actionable Information	Reconcile Conflicting Evidence	Strength of Evidence Determined	Applicability Determined	Timely	Reflects Contemporary Practice
Guidelines	++++	++++	++++	++++	+	++
Systematic Reviews	+++	++++	++++	++++	+	++
Clinical Trials	+	+	+	+	+++	+++
Observational Studies	+	+	+	+	+++	+++

Legend: ++++ = To a Great Extent, +++ = To a Modest Extent, ++ = To Some Extent, + = Little to No Extent

Lumbar Transforaminal Epidural Steroid Injections

Review & Recommendation Statement

January 2013

NASS
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What is a reasonable maximum number of therapeutic transforaminal epidural steroid injections that a patient should receive within a six month period to treat lumbar radicular pain?

In the absence of sufficient evidence regarding a reasonable maximum number of lumbar transforaminal epidural steroid injections (LTFESI), it is the opinion of the work group that: (1) no more than two injections be used to attempt to achieve a beneficial response in the first instance, and (2) thereafter, it seems reasonable to use up to three injections in a six month period to reinstate and maintain benefit once it has been achieved. In order to justify repeat treatment, benefit should be evident in the form of reduced pain and/or improved function, along with reduced need for other health care.

Work Group Consensus Statement

The available evidence indicates that favorable outcomes for LTFESIs reported in the literature were achieved most often using one or two injections. Rarely did investigators require three or more injections to achieve

Summary

- Guidelines / protocols need to be context-sensitive
- Guidelines / protocols need to be environment-sensitive
- Bias is unavoidable?
- Are all the guidelines compatible with your system?
- Implementation may require adaptation.

https://youtu.be/3iEAMaHIFgQ