Dermatological Surgery Standard Operating Procedure UHL Dermatology LocSSIP

Change Description	Reason for Change
☐ Change in format	☐ Trust requirement

APPROVERS	POSITION	NAME
SOP Owner:	Speciality Doctor and Mohs Surgeon, Dermatology	Mr Andrew Sharp FRCSEd
Sub-group Lead:	Head of Service, Dermatology.	Dr Karen Harman FRCP DM

Introduction

Skin surgery is performed within the UHL Dermatology Outpatient Department at the Leicester Royal Infirmary.

This Standard Operating Procedure is the Local Safety Standard for Invasive Procedures (LocSSIP) document this is compliant with the National Safety Standards for Invasive Procedures (NatSSIPs) guidance.

Procedures covered include:

- Curettage and cautery
- Shave excisions.
- Punch biopsies.
- Incisional and excisional biopsies
- Mohs surgical procedures
- Reconstructive skin flaps and skin grafts

This LocSSIP does not include patients who are scheduled for dermatological surgery outside of the outpatient department.

Patients who need skin surgery or biopsies are referred from UHL and Alliance dermatology outpatient clinics and from ward referrals in UHL seen by the dermatology team.

List management and scheduling

Patients are referred for procedures on the 'Dermatology Operation Booking Form' which must be completed in full and includes the prioritisation of the procedure, the level of complexity of surgery and the lesion characteristics, including site and size.

The Booking Form includes a checklist of operative risk factors.
A photo of the lesion(s) must be uploaded to Consultant Connect with an ink mark against the lesion to distinguish it from other nearby lesions. Patients who come via the 2WW artificial intelligence pathway will have photos within a document generated from the Skin Analytics platform which is uploaded onto DIT3.

Patients requiring hospital transport should not be listed for late afternoon or out-of-hours procedures.

Patient Preparation

Written information

Patients will be provided with a 'Skin Biopsy' booklet during their outpatient clinic appointment. This booklet provides the patient with information on what to expect when attending for their biopsy. If the first stage of consent is completed by telephone, the skin biopsy booklet should be posted to the patient (see SOP for telephone consent).

Planning for Mohs surgery

If patients have a clinically obvious BCC that may be suitable for MOHs surgery, and have been reviewed by a consultant, they may be referred directly to the MOHs assessment clinic after discussion of alternative treatments such as radiotherapy. If the diagnosis of BCC is uncertain, the patient should be referred for a diagnostic shave or curette biopsy of the lesion on a green referral form if suspected BCC or for a punch biopsy on an orange form if suspected SCC before their Mohs surgery - unless this has been deemed unnecessary by a Mohs surgeon or consultant.

Patients should be provided with a Mohs surgery information leaflet. Because of the potential for complex wound closure or the need for closure by another surgical speciality, patients referred for Mohs surgery should either be referred for a consultation with a Mohs surgeon or the referral discussed with a Mohs surgeon.

Clinical photography

It is mandatory for patients to have a photograph taken of the lesion to be biopsied to reduce the risk of wrong site/wrong lesion surgery which is an NHS Never Event. This will usually be done at the time of listing for surgery using Consultant Connect and the surgical request form reminds clinicians to take a photo. The index lesion should be identified, e.g. with an ink mark, to distinguish from other lesions in the same area. Similarly, if the patient is having an incisional biopsy and there

is a particular area to be sampled, this should also be marked in the photo.

Some patients may have had the first stage of consent taken by telephone – these patients will usually have had photos taken at a photography appointment and these will be available in a DIT3 letter or direct from the Skin Analytics platform. If there are technical problems with Consultant Connect, clinicians may take photos on the patient's phone to be brought to the surgical appointment – if this is the case, it should be recorded on the surgical request form and in the clinic letter. There may be rare occasions when a photograph is not available, and this should be documented, including the reason why, on the surgical request form and in the corresponding clinic letter. Similarly, there may be other reasons why there is no photo, e.g. the patient has declined a photo in a sensitive area, and this should also be recorded on the surgical request form and in the patient letter.

Medication
Patients can continue to take their medications as usual in most cases. This includes blood thinning drugs such as aspirin, warfarin, clopidogrel and DOACs. Consult the British Society of Dermatological Surgery Guidance on Antithrombotics and Skin Surgery 2023 for further information. Patients on warfarin will be asked to have an INR checked within 3 days of their surgery. If the INR is 3.5 or above surgery may only proceed if the surgeon considers this safe.

See Anticoagulation SOP Appendix 2

Electrical devices
Patients fitted with a pacemaker, or other implantable electronic devices will need bi-polar leads attached to the hyfrecator if they need diathermy. Patients with an implantable cardioverter defibrillator (ICD) should be referred to Plastic Surgery as there are no facilities to de-activate these devices in the department.

Patient mobility
If a patient has mobility problems and will be unable to transfer from a wheelchair onto a surgical couch without the aid of a hoist, the patient should be referred to Plastic Surgery as dermatology does not have the resources to manage such patients. Exceptions may be made for simple procedures that could be safely performed in their chair.

Consent
Patients will complete a consent form with the clinician during their outpatient clinic appointment. Standard complications and morbidity risks that patients should be informed of in the consent process include:

- Pain or discomfort
- Bleeding or bruising
- Scarring
- Wound Infection
- Nerve injury if risk
- Further surgery
- Wound dehiscence

- Possible need for further treatment

Confirmation of consent should be discussed with the patient before their procedure by the operating surgeon and the consent form signed by the operating surgeon in the confirmation of consent section of the form.

There are some circumstances when the first stage of consent will have been conducted by telephone. In this situation, the need for extra time to take written consent on the day of the procedure should have been noted on the surgical request form and an extra 10 minutes added. Alternatively, the clinician may have completed the consent form whilst taking the patient through it on the telephone. In this case, extra time will not be added but the consent form will need to be signed by the patient at the time of surgery.

Infection prevention
Prior to any procedure the operating staff should thoroughly cleanse their hands following Trust guidance on hand washing. Before any procedure they should also apply alcohol foam prior to putting on their gloves.

Aseptic non-touch technique (ANTT) will be utilised for all procedures. This may need to be modified according to the particular environment and type of patients seen in the dermatology department.

Pre-operative skin prep. When operating away from mucosal surfaces (eyes, nose, mouth and genitalia) a spirit-based cleanser e.g. Chloraprep is preferable. However, when operating near mucosa or other sensitive sites an aqueous cleanser should be used.

Sterile gloves, aprons and appropriate surgical masks should be worn by all operators and assistants.

Workforce – staffing requirements

The minimum UHL safe staffing standards for a procedure list include one surgeon and one assistant. The surgeon could be an appropriately trained Doctor, including a Dermatologist or Plastic Surgeon, or an appropriately trained Registered Nurse. The assistant can be a registered nurse or Nursing Associate, healthcare support worker or a medical student that has been deemed competent in the operating room procedures.

Learners or students will be supervised in the area by either the surgeon or the assistant.

Newcomers to the surgical suite must be trained and competency assessed by a peer who has previously been deemed competent in the procedure. For both Registered Nurses and Nursing Associates and Health Care Assistants, this should be recorded in the competency assessment documentation.

Procedural Verification and Site Marking

All patients undergoing dermatological surgery must undergo safety checks that confirm both the procedure to be performed and the site and side of the procedure.

It is crucial that the team pause from their duties to ensure that their attention can be focussed during these checks.

These safety checks must involve the surgeon, assistant, patient and /or family members/ significant others where possible.

These verifications must be performed at the Surgical Safety Check 'Sign in' (detailed below).

Surgical site marking is mandatory for all procedures for which it is possible. Pre-operative marking has a significant role in promoting correct site surgery, including operating on the correct side of the patient and / or the correct anatomical location or level (e.g. the correct finger on the correct hand).

Marking the surgical site may constitute outlining the surgical excisions and/or reconstructive options. Best practice demands that marking the operative site must be undertaken by the surgeon performing the procedure, although in certain situations a senior consultant may mark-up the site for a junior surgeon to operate on. Site marking should be performed with an indelible gentian violet marker pen designed for that purpose.

The process of pre-operative marking of the intended site must involve the patient and /or family members/ significant others where possible.

Confirmation of site marking must be documented on the surgical safety checklist. If none is required, justify why not.

Team Safety Briefing

The Team Safety Briefing must occur at the start of the operating session. As many members of the procedural team as possible should attend the briefing, with a minimum of one surgeon and one assistant present.
Any team member may lead the safety briefing.
Team members should introduce themselves to ensure that their roles and names are known, to encourage people to speak up.

The discussion should include:

- Equipment availability
- Availability of bipolar leads

Any additional concerns should be discussed, and contingency plans made.

All the clinical notes for the list must be checked. **The team must verify that all details on the 'Consent form', 'Minor Ops Booking Form' and the 'Clinical notes' correspond with the intended procedure before continuing.**

Every team member should be encouraged to ask questions, seek clarification or raise concerns about any aspect of patient care or the planned procedure.

The dermatology service has been an early adopter of the **"Stop the Line"** policy.

Sign In

All notes apart from that of the patient undergoing the procedure should be removed from the operating room and placed in the locked trolleys outside the room.

No relative or carer is permitted to stay in the operating room during the procedure except when it is considered essential by the operating surgeon.

All patients undergoing dermatological surgery must undergo surgical safety checks (See Appendix 1) beginning with the 'Sign In', then 'Time Out', and finally 'Sign Out'. These are based on the checks in the WHO Surgical Safety Checklist which was launched to address safety issues within the surgical setting. The surgeon and assistant must take part in the checks. The surgeon is responsible for leading and signing for the 'Sign In'.

The checks performed during the sign in should include, but are not limited to:

- The patient's identity should be confirmed with the patient from the hospital notes, their wristband and the consent form including name, address and date of birth.
  The surgeon must confirm with the patient that the signature on the consent form is the patient's or their guardian's.
- Confirmation of what site and procedure is planned.
- Completion of a valid consent form in accordance with the UHL Policy for Consent to Examination or Treatment (including confirmation of consent).
- It is mandatory to view the photograph of the surgical lesion on Consultant Connect, in the Skin Analytics letter on DIT3 or on the Skin Analytics platform. The surgical site can, in addition, be

confirmed with a mirror, the surgical request form, the clinical notes and the clinic letter. If in any doubt, ask for the opinion of a senior colleague. If an image is not available but the operator is happy to perform the requested procedure, write the reason for proceeding with surgery on the surgical checklist and always get a second opinion to check the site, ideally from the person requesting surgery or from a colleague – the operator should be confident that they have been able to identify the intended lesion from the information available and if there is any doubt, it is better to Stop The Line rather than proceed and remove the wrong lesion, which would be classified as a Never Event.

- Marking of the surgical site.
- Confirmation of any known allergies.

Local Anaesthetic

Maximum doses for adults of Local Anaesthetic drugs are as follows (The BNF):
Bupivacaine: 150mg (for up to four hours).
Lignocaine: 200mg without adrenaline, and 500mg with adrenalin (max dose of adrenaline is 500 micrograms; care should be taken when using adrenaline near terminal arteries).

Maximum volumes in ml of Local Anaesthetics corresponding to the BNF Maximum Doses:

- Bupivacaine 0.25%: 60ml
- Lignocaine 1%: 20ml without adrenaline, 50ml with adrenaline.
- Lignocaine 2%: 10ml without adrenaline, 25ml with adrenaline.

Sodium bicarbonate 8.4% may be added to 1% lignocaine by the operating surgeon at a volume ratio of 1 part sodium bicarbonate to 10 parts lidocaine.

Time Out

The ‘Time Out’ is the final safety check that must be completed for all patients undergoing invasive procedures just before the start of the procedure.

The assistant is responsible for leading and signing the Time Out

- The assistant must ensure that a completed histology request form is present and create a matching labelled histology specimen pot. The patient details should also be recorded in the histology specimen record logbook.
- The patient must confirm their identity & confirm that their details on the specimen pot(s) are correct.
- If there is more than one specimen, each should be placed in different pots and the pots and

histology form(s) clearly marked for each specimen.

The procedure must not commence unless the 'Time Out' has been completed.
The 'Time out' is the final safety check that must be completed for all patients undergoing invasive procedures just before injection of local anaesthetic.

Performing the Procedure

Aseptic technique will be used. The sterility of the instruments must be maintained.
Employees have a duty to follow the arrangements set out within the UHL Sharps Management Policy for the safe use of sharps.
The operator should check the patient's identity and check it matches the details on the labelled pot(s) as the specimen is placed into it during the procedure.

Monitoring

No specific monitoring is performed during procedures. Sedation is not used.

Prevention of Retained Foreign Objects

Given that dermatological surgery is superficial, does not penetrate deep fascia or enter body cavities a mandatory count of surgical instruments or swabs is not required.

The sharps must be counted by the surgeon at the end of the procedure. The disposal of sharps is the responsibility of the surgeon and therefore must not be handed to anyone else for disposal.

The surgeon should inform the assistant that all sharps have been cleared from the trolley to avoid needle stick injury during the placement of dressings.

Sign Out

The surgeon is responsible for leading and signing for the 'Sign Out'.

The sign out should include:

- Confirmation that the procedure has been recorded in the record logbook.

- Confirmation that sharps have been disposed of as per trust policy.
- Confirmation that specimens have been labelled correctly.
- The surgeon and assistant must jointly confirm that the specimen is inside the pot.
- The surgeon and assistant must confirm that the correctly labelled pot containing a specimen is placed into the matching completed histology request form and that the bag is sealed.
- Confirmation that the patient has been given an aftercare leaflet.

The surgeon and assistant must sign the specimen book to confirm the specimen and form have been checked personally by them.

- In suspected Squamous Cell Carcinoma, the SCC label should be placed on the histology form and all fields filled in to allow staging of the tumour.
- The number of specimens sent should be marked on the procedure record in long hand.
- If there is more than one specimen, each should be placed in different pots and the pots and histology form(s) clearly marked for each specimen.
- All specimens on patients referred on an orange Dermatology Operation Booking Form should be marked on the histology request form as ‘2 week wait’.

Following completion of the procedure and “sign out” checks, all notes, samples and any other paperwork must be removed from the operating room BEFORE another patient’s documentation is brought into the area.

Pathology pots and forms for each session are bagged up together to reduce the risk of samples being lost in transit.

Outcome Sheet

The outcome sheet must be completed for all patients, including action on patients who did not attend.

If the patient needs a wound review, this should be marked on the outcome sheet, including whose list and when.

Team Debrief

A verbal team debrief should occur at the end of all procedure sessions. All team members should be present. The surgeon will lead the team debrief.

The content of the debrief should include:

- Things that went well
- Any problems with equipment or other issues
- Areas for improvement
- A named person for escalating issues to management

Post-procedural Aftercare

No formal monitoring arrangements are necessary following the procedures as they are carried out under local anaesthetic. If any patient does become unwell, they can be nursed in the outpatient department 'recovery area' adjacent to the surgical suites.

Discharge

Patients are discharged from the surgical suites upon completion of their procedure.
Follow-up arrangements are made by the surgeon. Any results are either communicated via post or during a follow-up outpatient clinic appointment.

Did Not Attend

If the patient does not attend their procedure, the Outcome Sheet should indicate what action the administrative staff should take. A letter should also be dictated to the referring clinician and GP.

Change of Operative Plan

If the operating surgeon believes on pre-operative assessment of the lesion that the procedure type listed on the booking form should be changed (for example from excisional to diagnostic biopsy), they should discuss the reasons for this with the patient, write in the notes, fill out the outcome sheet with the altered follow up action, and dictate a letter to the referring clinician. They should also discuss the change with a senior colleague.

The consent form should be re-written to reflect the changed procedure type and signed by the patient and operating surgeon.

Governance and Audit

Safety incidents in this area include:

- Wrong site surgery
- Incorrect surgery
- Empty or mislabelled specimen pots
- Sharps injuries

All incidents must be reported on Datix. Incidents will be handled and reported in line with the usual Trust internal clinical incidents reporting mechanisms.

WHOBARS will be carried out on the Safer Surgery Checklist on a monthly basis.

All clinical incidents will be reviewed at the CMG monthly Quality and Safety board and at the quarterly Dermatology Morbidity and Mortality meetings.

Compliance with this SOP will be monitored by audit on an annual basis and monthly by WHOBARS assessment.

Training

Staff will be trained in this SOP by:

- Consultant staff
- Trust grade surgeon
- Designated specialist nurses trained in dermatological surgery.

References to other standards, alerts and procedures

Policy for Consent to Examination or Treatment, University Hospitals of Leicester 2015:
Sharps Management Policy, University Hospitals of Leicester 2016:
http://insitetogether.xuhl- tr.nhs.uk/pag/pagdocuments/Sharps%20Management%20UHL%20Policy.pdf

National Safety Standards for Invasive Procedures, NHS England 2015:
https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/09/natssips-safety- standards.pdf
UHL Safer Surgery Policy: B40/2010
UHL Sedation Policy: Safety and Sedation of Patients Undergoing Diagnostic and Therapeutic Procedures B10/2005
UHL Consent to Treatment or Examination Policy
A16/2002 UHL Delegated Consent Policy B10/2013
UHL Guideline: Anticoagulant Bridging Therapy for Elective Surgery and Procedures B30/2016
Department of Dermatology Anticoagulation SOP in shared drive.

Appendix 1. Safer Surgery Checklist 2022 (See PowerPoint slides)
Appendix 2. Anticoagulation Guidance for Surgery SOP