Dermatological Surgery Standard Operating Procedure UHL Dermatology LocSSIP

Introduction and Background:
Dermatological surgeries are 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 with suspicious or inflammatory skin lesions are referred for dermatological surgery from the UHL dermatology outpatient clinic.
List management and scheduling:

Wherever possible the appropriate grade of surgeon and time allocated for surgery should be indicated when the patient is initially seen and consented. This will allow the timely allocation of surgery slots. Patients requiring hospital transport should not be listed for late afternoon or out of hours procedures.

Patient preparation:

Patients will be provided with a ‘Skin Biopsies’ information booklet during their outpatient clinic appointment. This booklet provides the patient with information on what to expect when attending for their biopsy. Patients do not need to fast pre-operatively as the procedures are performed under local anaesthetic. Patients can continue to take their medications as usual. This includes blood thinning drugs such as:

- Aspirin, Warfrin or Clopidogrel

Pre-procedural investigations required:

- Blood tests for patients on Warfarin – parameters INR<3.5 (or above with agreement of surgeon).

Patients fitted with a pacemaker or any electrosurgical device may 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.

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

- Pain or discomfort
- Bleeding or bruising
- Scarring
- Wound Infection
- Further surgery
- Wound dehiscence
- Possible need for further treatment

Confirmation of consent should be discussed with the patient before their procedure and the consent form signed.

Infection prevention strategies include:

Prior to any procedure the operating staff should thoroughly cleanse the 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 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 otherwise when operating near mucosa or other sensitive sites an aqueous cleanser should be used.
- Sterile gloves
- Aprons
Workforce – staffing requirements:

The minimum safe staffing standards for a procedure list include one surgeon and one assistant. The assistant can be a nurse, healthcare support worker or a student that has been deemed competent in the area.
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 this procedure. For both Registered Nurses and Health Care Assistants, this should be recorded in the competency assessment documentation.

Procedural Verification of 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.
The verification of the intended procedure site must involve the surgeon, assistant, patient and /or family members/ significant others where possible.
The team must verify that the details on the ‘Consent form’, ‘Minor Ops Booking Form’ and ‘Histopathology Form’ correspond with the intended procedure before continuing.
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). Best practice demands that marking the operative site must be undertaken by the surgeon performing the procedure. Site marking should be performed with an indelible marker 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.
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 patients undergoing dermatological surgery must undergo surgical safety checks beginning with the ‘Sign In’. Along with the ‘Time Out’ and ‘Sign Out’, this is 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 ‘Sign In’ is the final safety check that must be completed for all patients undergoing invasive procedures just before injection of local anaesthetic.

The checks performed during the sign in should include, but are not limited to:
- The patient’s identity should be confirmed, including name, address and date of birth.
- Confirmation what site & procedure is planned.
- Completion of a valid consent from in accordance with the UHL Policy for Consent to Examination or Treatment.
- If applicable: the surgical site is to be checked in a mirror or identified from a photo.
- Marking of the surgical site.
- Confirmation of any known allergies.
- Confirmation of any anticoagulant use.
- Confirmation of whether the patient has a pacemaker/electrical device fitted.

Anaesthesia must not commence unless the ‘Sign In’ has been completed.

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 adrenaline (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%: 20mg without adrenaline, 50mg with adrenaline.
- Lignocaine 2%: 10mg without adrenaline, 25mg with adrenaline.

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 for 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 put into the histology specimen record logbook.
- The patient must confirm their identity & confirm that their details on the specimen pot are correct.
The procedure must not commence unless the ‘Time Out’ has been completed.

Performing the procedure:

Aseptic technique will be used.
Employees have a duty to follow the arrangements set out within the UHL Sharps Management Policy for the safe use of sharps.

Monitoring:

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

Prevention of retained Foreign Objects:

All surgical instruments must be counted at the end of the procedure to ensure that no foreign objects are retained unintentionally. The count should be done by the assistant and a record of the count documented on the paperwork that accompanies the instrumentation sets.
The sharps must be counted by the surgeon at the end of the procedure. The disposal of sharps are the responsibility of the surgeon and therefore must not be handed to anyone else for disposal.

Sign Out:

Sign out must occur before the patient leaves the surgical suite.
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. This must be completed before collecting the next patient.
- Discussion of post-procedural care with the patient.
- Confirmation that the patient has been given an aftercare leaflet.

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 monitoring arrangements are necessary following the procedures as they are done 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.

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.

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.

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:
National Safety Standards for Invasive Procedures, NHS England 2015:
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