

Personal reflection on intermediate anaesthetic practice



**ASSIGN
BUSTER**

I am a student anaesthetic practitioner with a clinical placement in an acute hospital. I will be reflecting on my personal experience with a 20 year old patient who underwent a Myringotomy and Bilateral Ear Grommets Insertion procedure wherein a local anaesthetic was used and had failed, and prompting the case to be done under general anaesthesia. The operation was deemed necessary by the consultant as the patient was diagnosed with recurrent Otitis Media with Effusion (OME), ' see Appendix A [on page 23]', because it will eventually help to correct his hearing loss and prevent further deterioration as stated by Woolfson and McCafferty 1993.

Following the NMC Code of Conduct (2008) on Confidentiality of patient's information, I will refer to patient as Mr. B. I will be using the Gibb's Reflective Cycle which is shown in Appendix B as the framework of my reflection Jasper (2003). It will highlight how researching further led to a better understanding of surgery and anaesthetics and to know how to respond if the same situation happens again.

Mr. B. had been admitted in the ward at noontime of the surgery. He was seen by the anaesthetist to carry out a preoperative assessment. According to the anaesthetist, he is generally fit for surgery and does not pose as an anaesthetic risk. The anaesthetist discussed with him about her plan to give him a general anaesthesia, but he asked the anaesthetist if the operation can be done without having a general anaesthetic because he prefers to remain awake. The consultant surgeon also came in and explained the surgery. He was allowed to undertake a local anaesthetic provided that he cooperate well and if the local anaesthetic is unsuccessful, an alternative anaesthetics will be used, that is a general anaesthesia. The surgeon and

<https://assignbuster.com/personal-reflection-on-intermediate-anaesthetic-practice/>

anaesthetist explained what he will experience with local anaesthetics like a burning sensation in his ears, including possibly a degree of pain. Any anaesthetic may arise complications and that other types of anaesthetic is not sufficient for the surgery and therefore needs to be changed to a general anaesthetic at any time (Box Hill Hosp. Dept. of Anaesthesia, 2001). A written consent was obtained by the surgeon from Mr. B. The Department of Health Guidelines (2007) on Consent states that Informed Consent ensures the patient has full knowledge of the procedure because it is fully explained to the patient by the surgeon. The patient is also given the time to ask any questions he may have and voice any concerns and honest answers must be provided.

I was assigned in the ENT theatre for the afternoon session which has three booked cases. The operating department practitioner (ODP) and I did the necessary checks in the anaesthetic room and safely prepared the anaesthetic materials and equipment in preparation of the list (AAGBI 2004). I also checked the safe and correct functionality of the anaesthesia machine and refilled drugs in the anaesthetic cupboards. Shields and Werder (2002) said that adequate preparation of the anaesthetic equipment, resources and patient is essential to the provision of safe anaesthetic care. The team members gathered to initiate a preoperative briefing. During the briefing, the surgeon mentioned about the order of the list. Mr. B will be done last as he is a private case anyway. After finishing the first two cases, the ODP and I went to the waiting area of patients to fetch Mr. B. I introduced myself and checked his identity. Then I checked that all preoperative preparations were done and documented. The consent form was confirmed to him that it was

his signature and dated. As the patient was having a Myringotomy and Bilateral Ear Grommets Insertion, the site of his procedure was not marked. For most procedure, this is an important check. The National Patient Safety Alert NPSA (2005) recommend that by marking the site for the operation with an arrow using a permanent marker will assist in reducing the incidents of wrong site surgery being performed. I also checked him for any allergies, presence of any metalwork, prosthetic aids in his body, contact lenses, crowns and dentures and asked if he has any other significant surgery or illness. Then I accompanied him to the operating room and made him lay down comfortably. While conversing with him, I placed on the external non-invasive monitors such as the blood pressure, ECG and pulse oximeter. I tried to maintain a quiet and supportive environment. I sat beside him and continued to communicate with him as he looked anxious. Kumar (2000) said that patients are apprehensive about what will happen and the anaesthetic practitioner needs to monitor patient's anxiety level throughout the surgical procedure. Meanwhile, the circulating nurse initiated the Time Out check which is carried out in every operation to enhance a safe surgery (World Health Organisation Guidelines for Safe Surgery, 2008).

The surgeon applied the local anaesthetic drug Ametop gel 4% onto Mr. B's ears. Woolfson and McCafferty (1993) suggest that it should be instilled into the external ear canal using a soft, intravenous cannula and a 5ml syringe and performed under a microscope to ensure immediate contact of the gel with the entire ear drums and that the ear canal was filled and the depth of the gel provides self occlusion. According to the BNF (2010) Ametop is a topical local anaesthetic in gel form which contains Tetracaine base 40 mgs.

believed to act by blocking nerve conduction mainly by inhibiting sodium ion flux across the axon membrane. The ester type “caine” anaesthetics are rapidly metabolised in blood mainly by plasma pseudocholinesterase. A slight erythema local skin reaction will be usually seen at the site of the application and as a result of the pharmacological action of tetracaine dilating the capillary vessels. This helps in delineating the anaesthetised area as explained by the National Library of Guidelines (2007). Adequate anaesthesia can usually be achieved following 30-60 minutes application time and anaesthesia is maintained for 4 to 6 hours in most patients after a single application. We waited only for about 30 minutes to anaesthetise his ears. While waiting, Mr. B became anxious as he was seen perspiring a lot. Everyone reassured him. The surgeon began cleaning and draping the area. Working with an operating microscope, the surgeon started to suction and made a small incision in his eardrum. Mr. B reacted to the pain but I encouraged him to keep still. The surgeon continued to suction the fluid present in the middle ear but Mr. B kept on moving his head because the pain was more intense. A tiny grommet was to be inserted into his surgical aperture but he refused as he cannot bear the intense pain. The surgeon stopped and asked the patient not to move if he wanted the operation to continue or if he cannot tolerate, he will be put to sleep instead. Mr. B and the whole team proceeded further as consented.

The anaesthetist cannulated Mr. B. using a gauge 18 large bore venflon secured with a transparent and semi permeable dressing connected to a litre of Hartmanns solution which has been labelled and checked by the anaesthetist and the ODP as per NHS protocol for intravenous infusion, AfPP

(2007). Clarke and Jones (1998) describes that a Hartmanns or sodium lactate or lactated ringer's is a crystalloid type of intravenous fluid that will cross a semipermeable membrane, thus allowing movement of electrolytes to correct any imbalance. It contains calcium, chloride and lactate similar in composition to extracellular fluid as a balanced salt solution. The anaesthetist started the induction and an I-gel airway (see appendix C) was inserted. The surgery was resumed and carried out without any problems. Mr. B. was fully recovered and transferred back to the ward without complications.

I felt disappointed because the result of this experience was clearly contrary to initial expectations. A minor operation like this can be done under local anaesthetics and is a quick procedure. It could have finished if only the patient cooperated well. Although this experience was frustrating for the patient as he requested to be awake during the procedure, still it went well and the treatment for a possible hearing loss and deterioration was done for him.

The duties and responsibilities expected from me as an anaesthetic theatre practitioner were performed according to the policies and procedures of my clinical placement. The whole team cooperated well and performed their job accordingly. I have also found out a controversial issue regarding the Ametop gel which has aroused my doubt. Netdoctor (2004) points out that Ametop is a topical anaesthetic for dermal analgesia which must not to be applied to broken skin, mucous membrane or to the eyes or ears. Tetracaine gel could be ototoxic like other local anaesthetics and should not be introduced to the middle ear or use in procedures which might involve <https://assignbuster.com/personal-reflection-on-intermediate-anaesthetic-practice/>

penetration into the middle ear. Therefore, Mr. B. might be at risk for ototoxicity. In addition to that, the local anaesthetic did not fail but it is because the surgeon did not wait longer enough until Mr. B was pain free before starting the surgery. A proper consent was secured earlier from him, thus, saved the time in securing a fresh consent. Moreover, it saved NHS resources akin to if the list was cancelled and rescheduled and along with the unsatisfactory hospital experience of Mr. B. The surgery could have been done quickly and safely under a most and effective local anaesthetic rather than topical and waiting for a clinically acceptable anaesthesia before commencing the surgery. I suggest that next time this event occurs again, I would tell the whole team in the preoperative briefing, to give ample time for the anaesthesia to take effect before we can start the surgery. I would also write an incident report so that a proper evaluation could be done and errors will be omitted in the future for the safety of the patient.