

The patient's journey

So you can put the operation into context for the patient, here is a typical "patient journey" for elective or planned surgery:

1. G.P. referral: the patient's General Practitioner decides that the patient has a condition that may require surgery and refers the patient to the hospital (usually a few days or weeks later).
2. Outpatient clinic: the patient comes to the clinic where s/he sees a Consultant Surgeon, or another doctor or nurse in the team. The "history" is taken, the problem part examined and some test may be requested. If the decision is made that an operation might help, the risks and benefits are discussed with the patient, and the doctor fills out a "waiting list card" and signs a "consent form" with the patient.
3. Pre-Assessment clinic: the patient attends a clinic to see a doctor or nurse, to check whether they are fit for surgery and for an anaesthetic, and whether they need any special care or medication to help them (eg if they have heart problems).
4. The Admissions department contact the patient to confirm a date for the surgery.
5. The patient attends on the morning of surgery, usually having had no food for 6 hours and no drink for 2 hours. (This is to avoid the risk of damage to the lungs from stomach contents while they are being put to sleep.)
6. The nurses on the ward or the Admission Lounge check everything is OK
7. The surgeon checks the patient on the morning of surgery, and puts an arrow on the part to be operated on, and countersigns the consent form.
8. The anaesthetist assesses the patient on the morning of surgery.
9. When it is this patient's turn, the theatre staff "send for" the patient, asking a porter to collect the patient.
10. The patient is taken to the operating theatre suite, often into the Anaesthetic room. There is a checklist, to make sure the right patient is ready for the right operation. (This is done very carefully.)
11. The Anaesthetist administers the anaesthetic and stays monitoring the patient throughout the operation. S/he works with an Anaesthetic-trained nurse/O.D.P.
12. The patient is moved into the operating theatre.
13. Everyone helps position the patient so that the part to be operated on is accessible.
14. The surgeon "scrubs" his/her hands, and puts on a green or blue sterile gown and gloves. The surgeon may not touch anything that is not sterile.

15. (The "scrub person", a nurse or O.D.P., has already checked all the kit, and "scrubbed, gowned and gloved".)
16. The surgeon and scrub person "prep" the patient, painting the skin of the area with an antiseptic solution. (This is often brown or pink.)
17. The surgeon and scrub person "drape" the patient, so that s/he is covered with sterile towels, with only the "prepped" area exposed.
18. The surgeon does the operation.
19. Everyone helps make sure the patient is put back on their bed and is comfortable. The Anaesthetist makes sure that the patient is recovering from the anaesthetic.
20. The patient is wheeled into the Recovery room where one nurse or O.D.P. will stay with him/her until s/he is fully awake.
21. The team "send for" the next patient.
22. Everyone washes their hands between patients.
23. The surgeon writes the operation note, saying everything that happened, and listing instructions for "post-op" monitoring, and when the patient can go home, and a plan for when the patient will be reviewed again in clinic.
24. When the patient is fully awake and stable the recovery nurse or O.D.P. escorts him/her to the ward.

Some patients have emergency operations. These patients are referred either from their G.P. or via Accident and Emergency. They are assessed by the surgical team, and if a decision is taken that surgery is needed, their name is added to an operating list. Some lists are kept empty for emergency admissions. We try to avoid operating at night, unless the operation is life-saving or limb-saving. The patient may have tests and be prepared overnight for a "Trauma list" or "CEPOD list" the next day.