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The operating theatre in a hospital is a highly critical and complex area which requires high hygienic standards. A certain code of conduct must be followed at all times to maintain a pedagogical model of excellence. There is indeed a very narrow margin for errors and critical incidents are waiting to happen with any lapses in the standard of care. The core idea of possessing certain etiquettes and mannerisms is therefore quintessential for excellence and safety in patient care and a good outcome. We as anesthetists play a pivotal role in maintaining the requisite standards. Let us revisit these sequentially to better equip ourselves in our temple of work- The Operating Theatre (OT)

Basic house rules mandate entering the OT in a well laundered clean two piece scrub suit, cap, disposable mask and proper footwear to minimize cross infection. The scrub suit is made up of cotton with a high weave density that minimizes the risk of bacterial strike-through. These should be changed immediately if soiled or contaminated.

Operating Theatre Mannerisms & Etiquette: Revisited!

Long sleeves are not allowed and bare below elbows must be strictly followed in all clinical areas. Proper footwear has ridged rubber soles to make it antistatic and anti skid to prevent slip and falls. (1)

Our next portal of contact is the patient which has to be impactful! This is a game changing opportunity and one must make the most of it! Through each and every step of anesthesia, one must be courteous, empathetic, reassuring and communicate adequately with the patient. (2) This would set the patient at ease and half the battle will be won! Vigilance with multitasking must be reflected at every step with positive communication. Dutt-Gupta et al have shown that negative communication during intravenous cannulation is known to have increased analgesic requirements in one study. (3)

Leave apart the humour, satire, sarcasm but the best surgeon - anesthetist relationship actually is a symbiotic one which thrives on professionalism, punctuality, discipline, mutual respect and assertiveness. We all do possess technical skills with great dexterity but one must possess non technical skills which sets us apart from others. Arrive before time for performing the blocks. One must turn their penchant off for people pleasing and maintain integrity at all times. Strong work ethics is a must for success. Mistakes do happen and one must apologize and explain them. Perfect documentation of all events in the OT is essential as the law is very clear about it, if it is not mentioned in the

anesthetic chart-it has not happened!

In the recently concluded FIFA world cup 2018, the Croatian team taught us lessons for a lifetime. They did an unmitigated display of non-technical skills which are equally important for our working in theatre. These nontechnical skills are none other than task management, team work, situation awareness and decision making. Flin et al in their excellent article on Anesthetists' and non-technical skills have pointed out that deficiencies in these can contribute to medical error and adverse events.(4) Ghodki et al has demonstrated these non-technical skills with day to day examples in her editorial on soft skills for anesthetists.(5)

Quality Communication

Quality communication should be the key element of the OT milieu. Gawande et al documents 43% of adverse events to be due to communication failure. Lingard et al has noted 30% of adverse events due to lack of standardization and team integration. Reluctance to interrupt, fear of embarrassment, and concern of being misjudged or inability to verbalize thoughts are the most common causes of communication failure. The challenge is to overcome the barriers and speak up. (6) Two challenge rule of advocacy and curiosity practiced in aviation has been strongly recommended in OT and critical care setting as well. While advocacy means deliberate practice to express your concern without being offensive, curiosity is to understand others point of

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view. The bottom-line of effective communication is to give clear precise instructions and ensure that the loop is closed and correct action executed. Non verbal clues like facial expressions, body language and above all the ability to listen to others make a whole lot of difference. (7)

Infection Control

Another important area which definitely needs our valuable contribution is infection control. Practice your 5 moments of hand hygiene religiously. Use personal protection equipment (PPE) and sterile aseptic precautions while doing any invasive procedures like central neuraxial blockade (CNB) and central venous cannulation. There has been a lot of apathy regarding the use of face masks while performing CNB's. An observational study found that most cases of meningitis after CNB were due to Streptococcus, a commensal in the respiratory tract. Let's see what the CDC (Centre for Disease Control and prevention) has to say in this respect; facemasks should always be used when injecting any material or inserting a catheter into the epidural or subdural space, aseptic technique and other safe injection practices should always be followed for all spinal injection procedures. Excellent protection from an appropriate mask lasts for ~15 minutes. A proper large, soft, pleated, pliable mask (as opposed to a cloth mask) remains a good bacterial filter for up to 8 hrs. It is prudent to change mask after each procedure.

The correct segregation of healthcare waste on site is vital and we as anesthetists have our share of responsibility too! As a matter of fact during my training in England, I learnt by observing my seniors and consultants to dispose the sharps after use myself into the sharps can. Any contaminated or infectious disposables should be discarded in the yellow bag for further disposal. Black bag is meant only for non contaminated packaging, tissues, and disposable cups. (1)

Mobile Menace

The only word which comes to mind when I think of smartphones is menace.

However, these have become an integral part of the healthcare sector responsible for innovation, teaching and education, data entry and many others. It's difficult to dissociate smartphones but we can try to minimize its use in the OT. Apart of being a significant source of nosocomial infections due to handling of mobiles by healthcare professionals by contaminated hands, they are a potent source of distraction. Although anesthetists are trained in multitasking while maintaining situational awareness, it may sometimes result in lack of concentration. Sterile cockpit rules followed in aviation industry apply to OT environment as well. To prevent interference with medical equipment a safe 1m rule is followed although most of the equipments are not affected due to electromagnetic radiation. It would be a good idea to store mobiles in plastic bag to prevent cross contamination. Restricted use of mobiles is highly recommended with regulation of ring tones. (8) Needless to mention that use of unparliamentary language is strictly prohibited as it can lead to dire consequences.

With the use of smartphones, use of social media has become inevitable with a variety of websites and groups on facebook where patient information is shared for discussion and knowledge sharing. It is our singular responsibility to obtain patient's consent, hide PID (Patient Identifiable Data) to protect security and privacy and maintain confidentiality all the time.

“Unnecessary noise is the most cruel absence of care which can be inflicted either on sick or on well.” —Florence Nightingale, 1859

Specifically within hospitals, average noise levels of 45 dBA or less are recommended. Both National Institute for Occupational safety and Health and Occupational safety and Health Administration guidelines agree that the peak level for impulsive noise (characterized by a steep rise in the sound level to a high peak followed by a rapid decay) should not exceed 140 dBA. (9) The most common source of noise is loud chatter and music followed by

arranging metal instruments, suction apparatus, monitor alarms, air warming units, various mobile ringtones. The most commonly reported short term healthcare consequences are distraction leading to serious communication gaps, negative impact on anesthetist and surgeon performance, increased chances of surgical site infection especially when junior surgical staff is closing the wound with music playing in background. Thus, noise prevention is a collective responsibility to be shared by entire staff in OT for an error free surgery. Strict adherence to sterile cockpit rules during surgery as well as anesthetic critical moments like induction, extubation and administering CNB's and regional blocks. (9)

What you do has far more impact than what you say!- Stephen Covey.

Anesthetist being the team leader, MUST WALK THE TALK! The team members don't listen to what you say but follow what you do. The future is definitely bright for anesthetists with the introduction of non-technical skills in undergraduate curriculum.

Neurolinguistic programming and simulation training will further enhance our situational awareness and response to crisis moments.

Acknowledgment: I owe this editorial to all the members of TAS (The Anaesthetist Society) and especially Dr Shiv Kumar Singh whose posts and discussions have given me ideas galore and inspired me to think laterally and compose them

References

1. Operating theatre manual 2018: The Association for Perioperative Practice, UK
2. Kumar M, Chawla R: Communication skills and Anesthesiologists. *Anesth Essays Res.* 2013 May-Aug; 7(2): 145–146.
3. Dutt-Gupta J, Bowen T, Cyna AM. Effect of communication on pain during intravenous cannulation: a randomized controlled trial. *British Journal of Anaesthesia* 2007;99:871–5.
4. Ghodki P. Soft Skills for successful Anaesthesia Practice. *Journal of Anaesthesia and Critical Care Case Reports* Jan-Apr 2017; 3(1): 3-4.
5. R Flin, R. Patey et al: Anesthetists's non technical skills. *British Journal of Anaesthesia* 105 (1): 38–44 (2010)
6. Pian-Smith MC, Simon R, Minehart RD, Podraza M, Rudolph J, Walzer T, et al. Teaching residents the two-challenge rule: A simulation-based approach to improve education and patient safety. *Simul Healthc.* 2009;4:84–91. [PubMed]
7. Goyal R: Surgeon and anesthesiologist need to communicate. *J Anaesthesiol Clin Pharmacol.* 2013 Jul-Sep; 29(3): 297–298.
8. Attri JP, Khetarpal R et al: Concerns about usage of smartphones in operating room and critical care scenario. *Saudi J Anaesth.* 2016 Jan-Mar; 10(1): 87–94
9. Katz J: Noise in the operating room. *Anesthesiology* V 121: 894-8

Conflict of Interest: Nil
Source of Support: None

How to Cite this Article

Lande-Marghade P. Operating Theatre Mannerisms & Etiquette: Revisited! *Journal of Anaesthesia and Critical Care Case Reports* May-Aug 2018; 4(2):1-3.