GIRFT, BHS and BOA Best Practice for Hip Arthroplasty Surgery Documentation

Background and Justification:

This guidance has been produced by the Getting It Right First Time (GIRFT) programme in partnership with the British Hip Society and is aimed to provide advice on various aspects of surgery which should be available and clearly documented in a hip arthroplasty operation record. The document is not a comprehensive guide to hip surgery, however it is hoped that surgeons will find the advice it offers helpful.

It is expected that the standards listed would be included within the documentation of patient care and although the majority will be included in the operation note, the information could be contained elsewhere in the patient record including and not limited to pre-surgery documentation from outpatient and pre-assessment clinics, MDT meeting documentation, ward round entries, a separate WHO Surgical Safety Checklist and drug charts. The documentation where appropriate may be made by other members of the surgical team apart from the operating surgeon. However, it is the operating surgeon's responsibility to ensure that appropriate documentation has occurred.

It is important to note that the information in this document was produced from the analysis of medical negligence claims notified to NHS Resolution by NHS trusts, the experience of leading expert witnesses in orthopaedic surgery and a review of existing guidance. The complete document including case studies should be read in parallel with this summary.

Standards for documentation of practice in all patients undergoing hip arthroplasty surgery:

1. If used, record the results of preoperative templating and the outcomes of any MDT meetings used to discuss complex cases including who was present and the agreed actions.
2. Documentation of the informed consent process should be available, including the choice of implants, the potential use of bone graft or any other additional procedures as relevant.
3. Safety briefing, sign in, time out, and sign out as part of WHO Surgical Safety Checklist . The presence of required prostheses and any equipment required for their insertion should be confirmed .
4. Record names of all surgeons with name/grade of lead surgeon and assistants.
5. Record names and grades of anaesthetist(s) and type(s) of anaesthetic used.
6. Record patient position, skin preparation, surgical approach.
7. Identify steps taken to protect critical structures e.g. sciatic nerve in the posterior approach.
8. Record the preparation of the acetabulum including maximum size of reamer used, the quality of bone stock and then the cup size used and its' orientation as well as commenting on stability and the use of screws and augments.
9. For uncemented cups: a confirmation of liner material, size and accurate seating.
10. Record the broach size used for femoral preparation and any details regarding abnormal alignment or version.
11. With cemented stems record use of cement restrictor and implant centraliser as relevant .
12. Record the use of a trial of implants, the sizes involved, and the findings and plans made from that trial.
13. There should be a record, readily available from the patient's notes, of the implanted acetabular, femoral and femoral head components. The information required includes component, size, taper details, manufacturer, and expiry date.
14. The manufacturer's unique identifier label for the prosthesis should be attached for all components and uploaded to the National Joint Registry.
15. Record the type of cement used e.g. brand, use of antibiotics, quantity, and methods used to optimise cementation. The manufacturer's label for the cement detailing the batch number should also be attached.
16. It is preferable to use implants that manufacturers identify as compatible. A justification should be documented if ignoring manufacturer's guidance, e.g. in revision surgery.
17. For the second procedure in bilateral hip arthroplasty, knowledge of the previous implants and sizes is required, and any reason for deviation from these should be clearly documented.
18. Document positioning of final components, assessment of stability of hip and range of movement achieved before dislocation both in extension with external rotation and flexion with adduction and internal rotation.
19. Record all details of intra-operative concerns or complications e.g. fracture and their management.
20. Record clear details of closure.
21. Record drugs given during surgery e.g. antibiotics, tranexamic acid.
22. Record leg lengths and vascular status at end of procedure, and neurologic status once regional anaesthesia has worn off.
23. The post-operative plan for antibiotics, haemoglobin, AP and Lateral X-rays, and VTE thromboprophylaxis (including risk assessment and deviations from local protocol) should be documented.
24. Clear instructions should be given regarding post-operative mobilisation strategy and any concerns or deviation from standard practice should be identified.

EVIDENCE BASE:

[1] *WHO Surgical safety checklist, http://www.who.int/patientsafety/safesurgery/ss_checklist/en/*

[2] *National safety standards for invasive procedures, https://improvement.nhs.uk/resources/national-safety-standards-invasive-procedures/*

[3] *British Orthopaedic Association, Primary Total Hip Replacement: A guide to good practice, 2012, https://www.britishhipsociety.com/uploaded/Blue%20Book%202012%20fsh%20nov%202012.pdf*