Retrosigmoid Craniectomy

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| Specialty: Neurosurgery | Procedure: Retrosigmoid craniotomy |

Trainees should carry out the procedure, explaining what they intend to do throughout. If the trainee is in danger of harming the patient at any point s/he must be warned or stopped by the trainer immediately.

| **Competencies and Definitions** | | **Positive Behaviors**  (doing what should be done) | **Negative Behaviors**  (doing what shouldn’t be done) | **Negative – Passive Behaviors**  (not doing what should be done) |
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| I. Consent | | | | |
| C1 | Demonstrates sound knowledge of indications and contraindications including alternatives to surgery | Explains using examples relevant to the patient:   * Principle benefit of operation * Subsequent improvement of function * Limitations of surgery * Consequences of not having surgery | Expresses unrealistic views of the improvement in function expected following the procedure | Fails to point out the limitations of the operation |
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| C2 | Demonstrates awareness of sequelae of operative or non-operative management | Describes consequences, agrees expectations and checks patient understanding | Is over confident in describing consequences, reinforces patient’s unrealistic expectations | Fails to mention key inevitable consequences |
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| C3 | Demonstrates sound knowledge of complications of surgery | Explains in priority order the complications likely to occur in terms of commonality and in terms of seriousness | Spends time explaining rare complications and fails to mentions commoner ones | Misses out one or more major complication(s) when explaining to trainer or patient |
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| C4 | Explains the perioperative process to the patient and/or relatives or carers and checks understanding | Describes what will happen throughout the management of the condition, indicating clear post-operative milestones, giving a rough idea of time involved and specifying who will do what. Questions the patient to check that their expectations are realistic and they have understood fully | Uses technical terms, explains too quickly and does not check understanding | Misses out common events, particularly those likely to happen in the early post-operative period |
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| C5 | Explains likely outcome and time to recovery and checks understanding | Expresses sensible prognosis and clear has knowledge of the current outcome data | Expresses over optimistic outcomes and glosses over realistic difficulties | Fails to check that the patient has understood by actively listening to the patient’s reiteration of what is being said to them |
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| II. Pre-operative planning | | | | |
| PL1 | Demonstrates recognition of anatomical and pathological abnormalities (and relevant co-morbidities) and selects appropriate operative strategies/techniques to deal with these e.g. nutritional status | Articulates the realistic clinical findings against any investigative findings and achieves a balance between the two | Describes an operative plan without the full use of the clinical and investigative material | Fails to take into account specific medical conditions that might limits the technical choices |
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| PL2 | Demonstrates ability to make reasoned choice of appropriate equipment, materials or devices (if any) taking into account appropriate investigations e.g. MRI | Draws, writes or iterates pre-operative plan |  | Fails to check the notes for relevant or unexpected findings. Does note take into account investigative findings when planning or selecting the equipment |
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| PL3 | Checks materials, equipment and device requirements with operating room staff | Either personally visits or rings up the operating theatre to check on equipment availability | Delegates the task to ta more junior team member with no plans to check the instruction has been carried out | Fails to communicate with the theatre staff |
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| PL4 | Ensures the operative site is marked where applicable | Personally marks the site | Delegates the task of marking the site to a junior doctor or nurse | Fails to check that the site has been marked |
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| PL5 | Checks patient records, personally reviews investigations | Ensures that the relevant information such as investigative findings are present, checks wristband | During the procedure asks theatre staff to look something up in the notes | Fails to check notes to ensure all information is available that is needed |
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| III. Pre-operative preparation | | | | |
| PR1 | Checks in theatre that consent has been obtained | Checks the consent form in the notes | Leaves the consent checking to nurses or junior medical staff | Makes no effort to check consent form in the notes |
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| PR2 | Gives effective briefing to theatre team | Checks with nurse that they have all equipment needed ready to hand and discusses planned actions | Complains when something is not available during the procedure. Asks for something which results in theater staff going on a hunt for it | Makes no attempt to discuss operation with team |
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| PR3 | Ensures proper and safe position of the patient on the operative table | Prior to scrubbing supervises the position of the patient | Delegates the task to a theatre orderly and does not check | Concentrates on the process of scrubbing up while the patient is being transferred onto the operating table |
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| PR4 | Ensures proper and safe position of the patient’s head | Ensures the head of the patient is safely placed on headrest / Mayfield head clamp. Positions the patient’s head according to the planned surgical approach taking into consideration of clinical conditions and anatomical variation | Leaves the headrest or Mayfield head clamp unlocked. Position of the head incompatible with the surgical approach planned | Fails to check the patient’s head position |
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| PR5 | Ensures proper and safe positioning of headpins in cases where Mayfield head clamp is being used | Informs anesthetist about putting on head clamp. Makes sure the headpins do not slip, or causing any impingement onto the scalp, or being placed onto the temporalis muscle | Places headpins at insecure positions or may cause muscle bleeding | Fails to inform anesthetist about putting on head clamp or to check the position of headpins |
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| PR6 | Checks the positioning of all the body parts of the patient | Checks:   * Neck position for airway, venous drainage of the brain and brachial plexuses * All pressure points packing e.g. elbows and ankles | Delegates the task to a theatre nurse or orderly and does not check | Fails to check the positioning of the patient’s at risk area |
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| PR7 | Demonstrates careful skin preparation | Supervises painting of the operative field, ensures the material covers the whole surface | Paints (or supervises) the operative field leaving gaps or inadequate coverage | Delegates painting to an unsupervised member of the team or fails to check that the area has been adequately painted |
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| PR8 | Demonstrates careful draping of the patient’s operative field | Drapes (or supervises draping of) the operative filed to adequately expose site ensuring only prepared site is exposed | Exposes an inadequate area for the incision/access | Fails to secure drapes adequately |
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| PR9 | Ensures general equipment and materials are deployed safely (e.g. catheter, diathermy) | Checks with the anesthetic nurse that the diathermy has been placed well away from any existing metal implants | Delegates the task unsupervised to the anesthetic nurse or orderly | Fails to brief the team if metalware is in place in the other limb |
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| PR10 | Ensures appropriate drugs administered | Checks notes, liaises with anesthetic team to ensure prescribed drugs administered | Assumes drugs have been administered without checking | Fails to check with anesthetic team that drugs have been administered |
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| PR11 | Arranges for and deploys specialist supporting equipment (e.g. microscope) effectively | Briefs and discusses with the team where equipment is to be placed relative to the operative field | Takes no regard of where equipment is placed such as diathermy scabbard and/or places it in a position where the devices can’t be used safely | Ignores the set up procedure in the immediate pre-operative period and has a conversation with a third party |
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| IV. Wound opening and closure | | | | |
| E1 | Demonstrates knowledge of optimum skin incision | Verbally states or marks with a pen the anatomical landmarks prior to making the incision | Makes an incision that is clearly too small or too large | Does not extend an incision when struggling for access |
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| E2 | Deals with opened mastoid air sinuses adequately to prevent CSF leakage where appropriate | Closes all the mastoid air sinuses | Closes the mastoid air sinuses with inappropriate material | Ignores the opened mastoid air sinuses |
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| E3 | Completes a sound wound repair where appropriate | Closes each layer without tension | Ties very tight sutures, clearly strangulating soft tissue | Leaves too large a gap between sutures so that structures are not properly opposed |
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| E4 | Protects the wound with dressings, splints and drains where appropriate | Personally supervises the application of the wound dressing | Walks away from the operating table without briefing the assistant or the nurse on what they require to cover the wound | Fails to specify required dressing |
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| V. Intra-operative technique | | | | |
| IT1 | Follows an agreed, logical sequence or protocol for the procedure | Justifies actions at any point in procedure | Spends a lot of time removing superfluous tissue | When a difficulty is encountered fails to completer maneuver |
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| IT2 | Consistently handles tissue well with minimal damage | Personally places self retaining retractors and checks whether the skin is under tension | Pull and tears tissue. Allows the wound edges to become dry | Fails to recognize tissue damage |
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| IT3 | Controls bleeding promptly by an appropriate method | Responds calmly by applying pressure initially, briefs the team about what will need to be done – e.g. asks assistant to be ready for diathermy | Grabs in non-systematic manner at soft tissue and indiscriminately applies diathermy. Continues with a dissection despite welling up of blood in the field | Fails to act calmly. Fails to brief team. Fails to control blood flow |
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| IT4 | Demonstrates a sound technique of knots and sutures / staples | Draws soft tissue together without tension and forms proper reef knots | Pulls tissues tight so that the tissues blanche. Lets a wound edge gape or pulls one layer of tissue under another | Fails to use the correct method or technique |
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| IT5 | Uses instruments appropriately and safely | Asks for instruments in a timely manner anticipating what is needed | Uses and instrument for a purpose it is not intended. Takes whatever is given to them then complains | Fails to ask for correct instruments at the correct time |
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| IT6 | Proceeds at appropriate pace with economy of movement | Lets the nurse know what is to be done or needed next | Stops and starts, picking things up and then putting them down without using them. Spends a long time on a task not appropriate to the pace | Spends a long time on a task not appropriate to the pace |
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| IT7 | Anticipates and responds appropriately to variation e.g. anatomy | When encountering something unexpected stops and verbalizes concerns with the team | Persists in a task that is proving difficult and has to be stopped | Fails to recognize anatomical variation and has to be stopped |
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| IT8 | Deals calmly and effectively with unexpected events / complications | Verbalizes that there is a problem and briefs the team on what needs to happen next | Verbalizes negative concerns and issues conflicting instructions. Tries to continue inappropriately (has to be stopped) | Fails to brief the assistant adequately |
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| IT9 | Uses assistant(s) to the best advantage at all times | Briefs assistants and places them and the instruments where they are needed | Accepts whatever assistant does irrespective of whether or not appropriate | Fails to brief the assistant and expresses irritation when positions are not what are required |
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| IT10 | Communicates clearly and consistently with the scrub team | Sets positive tone with appropriate greeting. Asks for instruments clearly. Informs as to next steps. Asks for instruments by correct name | Uses rough or inappropriate tone of voice or words. Uses slang or local description so instruments | Gives no greeting, does not ask for anything (but expects to be given it) |
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| IT11 | Communicates clearly and consistently with the anesthetist | Sets positive tone with appropriate greeting. Sets clear goals and expectations | Proceeds with next step of procedure without anesthetic advice (where required) | Fails to inform anesthetist of key phase requiring anesthetic cooperation |
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| IT12 | Achieves an adequate exposure through purposeful dissection. Identifies and/or protects all surrounding structures (e.g. vertebral artery) | Anticipates important structures to be encountered. Implements measures to protect surrounding structures which are at risk of damage during dissection and retraction | Describes the structure encountered in the dissection in the wrong location. Damages surrounding structures during the dissection inadvertently. Exposes structures which are clearly unnecessarily or inadequately exposed | Tries to maintain the standard approach despite the fact that access is proving difficult. Fails to recognize and adjust to anatomical variation |
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| IT13 | Plans and open the appropriate burr hole(s) and craniotomy | Designs the burr hole(s) sites. Opens the craniotomy in a safe manner allowing adequate exposure | Makes the craniotomy / burr hole(s) that provides not adequate exposure on intracranial structures. Inadvertently damage surrounding structures e.g. sigmoid sinus | Does not extend the craniotomy / burr hole(s) when clinical and investigation (e.g. stereotaxy, intra-op USG) finding confirmed inadequate exposure |
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| IT14 | Achieves adequate relaxation of the posterior fossa through CSF drainage and positioning of the patient. Makes appropriate durotomy | Releases CSF at appropriate sites e.g. foramen magnum / lumbar drain. In cases needed, put the patient in head-up position for further relaxation of the posterior fossa. Makes appropriate durotomy to allow adequate exposure | Makes the durotomy clearly too small. Inadvertently damage the underlying cerebellum | Does not appreciate the fullness in the posterior fossa and conduct no measures to relax it |
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| IT15 | Retracts cerebellar hemisphere appropriately and safely, protects all the important structures e.g. lower cranial nerves and Dandy’s vein | Dissects the surrounding important structures e.g. lower cranial nerves and Dandy’s vein as much clear from the cerebellum as possible, so that the cerebellum can be retracted gently without damaging it | Damages the surrounding structures. Retracts the cerebellum too forcefully or causes damage to it | Fails to retract the cerebellar hemisphere |
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| IT16 | Achieves adequate exposure of the cerebellopontine angle | Anticipates to encounter and dissects contents in the cerebellopontine angle | Damages any of the contents in the cerebellopontine angle | Fails to identify the structures in the cerebellopontine angle. Fails to dissect the area for further procedure |
| VI. Post-operative management | | | | |
| PM1 | Ensures the patient is transferred safely from the operating table to bed | Personally takes part in the transfer of the patient from the operating table to the bed | Leaves the operating room prior to the transfer | Fails to check patient once they are in bed |
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| PM2 | Constructs a clear operation note | Makes a legibly written or clearly dictated note | Writes illegibly, mumbles on Dictaphone | Fails to write or dictate anything at all |
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| PM3 | Records clear and appropriate post operative instructions | Writes in clear text a list of post-operative instructions in the notes | Gives verbal instructions to a pass nurse | Fails to write anything in the notes at all |
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| PM4 | Deals with specimens. Labels and orientates specimens appropriately | Personally arranges specimens for pathologist | Delegates checking labels to junior | Does not label specimens |
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