NCEPOD Lower Limb Amputation: Working Together? report

Hospital Number _____

Recommendations	Data collection tool	Response		Action required
2) All patients with diabetes undergoing lower limb amputation should be reviewed both pre- and post operatively by the specialist diabetes team to optimise control of diabetes and management of co-morbidities. The pre-operative review should not delay the operation in patients requiring emergency surgery.	25. Did the patient have diabetes at the time of admission?	Refer to audit tool		
	26. Was the patient reviewed PRE-OPERATIVELY by the specialist diabetes team to optimise the control of diabetes and the management of comorbidities?	Yes	No	
	27. Was the patient reviewed POST-OPERATIVELY by the specialist diabetes team to optimise the control of diabetes and the management of comorbidities?	Yes	No	
	16. Please indicate the urgency of the procedure: - Immediate - Urgent - Expedited - Elective	Refer to audit tool		
	28. If the surgery was undertaken on an emergency basis, did the pre-operative review delay the operation?	Yes	No	
3) As recommended in the Quality Improvement Framework for Major Amputation Surgery (VSGBI), all patients undergoing major lower limb amputation should have a named individual responsible for the co-ordination of their rehabilitation and discharge (amputation/discharge co-ordinator). Their role should include the provision of detailed written information for patients and their relatives covering the whole clinical pathway.	11. Is there evidence in the case notes that a named individual was allocated to co-ordinate care, rehabilitation and discharge planning?	Yes	No	

4) The decision to undertake a major amputation should be made by a multidisciplinary team (MDT) including vascular surgery, physiotherapy, occupational therapy, diabetology, radiology, specialist nursing and an amputation/discharge co-ordinator. Where the urgency of surgery prevents this, as a minimum patients should be discussed with a consultant vascular surgeon and reviewed by a consultant anaesthetist, before amputation.	14a. Was the decision to amputate made by a multidisciplinary team? 14b. If YES, did this team include: I. Vascular surgery II. Physiotherapy III. Occupational therapy IV. Diabetology V. Radiology VI. Specialist nursing VII. Amputation/Discharge co-ordinator 14c. If NO to 14a, was this due to the urgency of surgery? 14d. If YES to 14c, was the patient discussed by a consultant vascular surgeon and reviewed by a consultant anaesthetist prior to amputation?	Yes Yes Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No No No No	
6) When patients are admitted to hospital as an emergency with limb-threatening ischaemia, including acute diabetic foot problems, they should be assessed by a relevant consultant within 12 hours of the decision to admit or a maximum of 14 hours from the time of arrival at the hospital, in line with current guidance. If this is not a consultant vascular surgeon then one should be asked to review the patient within 24 hours of admission.	6. Reason for admission - Ischaemic rest pain - Neuropathy - Diabetic foot sepsis - Other 3a. Date of admission 3b. Time of admission 3c. Was the patient reviewed by a consultant within 12 hours of the decision to admit or 14 hours from the time of arrival 7. If the patient was admitted with ISCHAEMIA or DIABETIC FOOT SEPSIS, were they reviewed by a consultant vascular surgeon within 24 hours of admission?	Refer to audit tool Refer to audit tool Refer to audit tool Yes Yes	 No No	
8) NICE recommends that a nutritional assessment of all patients should be made within the first 48 hours of admission (CG32). This guidance should be implemented for all patients requiring lower limb amputation.	8. Was the patient's nutritional state assessed within 48 hours of admission to hospital?	Yes	No	
		Refer to audit tool		

9) All patients admitted electively for lower limb amputation should be seen in a pre-assessment clinic to optimise medical co-morbidities and to plan post operative rehabilitation.	4. Admission category: - Elective - Planned - Emergency 5a. If admitted electively, was this patient assessed in a pre-assessment clinic (prior to admission for amputation)? 5b. If YES to 5a, was an attempt made to optimise any medical comorbidities? 5c. If YES to 5a, was a discharge or rehabilitation plan discussed and recorded at the pre-assessment clinic?	 Yes Yes Yes	 No No No	
10) For patients undergoing major limb amputation, planning for rehabilitation and subsequent discharge should commence as soon as the requirement for amputation is identified. All patients should have access to a suitably qualified amputation/discharge co-ordinator.	10. Is there evidence in the case notes that discharge planning and rehabilitation were discussed as soon as the requirement for amputation was identified? 12. Was the patient seen by an amputation/discharge co-ordinator pre-operatively?	Yes Yes	No No	
12) A consultant vascular surgeon should be present in the operating theatre for all amputations performed by a non-CCT trainee.	17. What was the grade of the primary surgeon who performed the operation? 18. If the operation was not performed by a consultant or non-CCT trainee, was a consultant present in the operating theatre?	Refer to audit tool Yes	 No	
14) All patients undergoing lower limb amputation must be screened pre-operatively for MRSA, as recommended by the Department of Health.	9. Was this patient screened for MRSA pre-operatively?	Yes	No	
15) As recommended in the Quality Improvement Framework for Major Amputation Surgery (VSGBI), amputations should be done on a planned operating list during normal working hours and within 48 hours of the decision to operate. Any case waiting longer than this should be the subject of local case review to identify reasons for delay and improve subsequent organisation of care.	19. Was the operation undertaken on a planned operating list? 20. Was the operation undertaken within normal working hours (as defined by your Trust)? 21a. Was the operation undertaken within 48 hours of the decision to operate? 21b. If NO, was the case the subject of local case review?	Yes Yes Yes Yes	No No No No	

17) Insulin should be prescribed according to National Patient Safety Agency (NPSA) recommendations.	29. Was insulin prescribed according to National Patient Safety Agency (NPSA) recommendations?	Yes	No	
18) Hospitals should have clear guidelines for the management of blood glucose levels when they are outside the acceptable range. These guidelines should be implemented for all patients undergoing lower limb amputation.	30a. Were the patients blood glucose levels outside the acceptable range at any point during the patients admission? 30b. If YES, were hospital guidelines on the management of blood glucose levels implemented?	Refer to audit tool Yes	 No	
19) A falls risk assessment should be undertaken in all patients undergoing lower limb amputation, and measures should be put in place to reduce the risk of a subsequent fall during the in-patient stay.	13. Was a falls assessment undertaken pre-operatively? 23. Was a falls assessment undertaken post operatively? 24. Were measures put into place to reduce the risk of falls during the inpatient stay?	Yes Yes Yes	No No No	
20) As recommended by the British Association of Chartered Physiotherapists in Amputee Rehabilitation and British Society of Rehabilitation Medicine, when it is possible to choose the level of amputation, the physiotherapist should be consulted in the decision making process regarding the most functional level of amputation for the individual. Post operative physiotherapy should commence on the first day where possible and should include exercise, oedema management and use of early walking aids as appropriate.	15. Is there evidence that a physiotherapist was involved in the decision making process regarding the level of amputation? 22a. Is there evidence that physiotherapy started on the first day post surgery? 22b. If YES, did this include: - Appropriate exercise - Appropriate and timely oedema control measures - The use of early walking aids where clinically indicated	Yes Yes Yes Yes Yes	No No No No No	