Editorial

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Developing Practice

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Editor-in-Chief

LIFE has been very hectic since the last issue of the *BJARN* with very little time to sit back and reflect on what I have been doing. I have been carrying out two jobs simultaneously. I have continued to work in the University running two modules I started after I handed in my notice, I felt that professionally I could not leave these students mid module especially as at that point there was no one to replace me. So I was given a honary senior lectureship for two days per week to run these two modules. In the other three days I was doing my other job, which by the time you read this will be my full time job, as the lead for a post anaesthetic care unit in a brand new direct treatment centre that will be undertaking total hip and knee replacements. We are starting with a clean slate, which means that we can do exactly as we want for the best of the patients and can put into practice all the good evidence based practice we have observed over the accumulated years all of us have been in nursing. It is very exciting and I have really enjoyed the challenge. We do not open until January (so again by the time you read this we will have opened!) and so that has given us a chance to sit down and develop policies and practices we are happy with.

It was whilst writing one of the policies that I had a chance to reflect. The policy was on preoperative fasting. I was reviewing the literature in order to make the policy not only as up to date as possible, but as evidence based as possible. We have known for a number of years that the evidence is overwhelming that patients should only be nil by mouth for food for six hours prior to surgery and fluids can be taken up to two hours prior to surgery and that prolonged fasting prior to surgery is not necessary and can have a detrimental effect on the patient [Crenshaw and Winslow, 2002; Smith *et al*, 1997; Yogendran *et al*, 1995; Hung, 1992].

In 1999 the American Society of Anesthesiologists (ASA) issued guidance based upon the evidence stating the six and two hour nil by mouth period and in this country guidance produced by the Association of Anaesthetist of Great Britain and Ireland (AAGBI) echoed these recommendations (AAGBI, 2001). However in a study by Crenshaw and Winslow [2002] they found that despite the advent of these guidelines practice had changed little. In the United Kingdom, Seymour [2000] found that despite a hospital policy advising a two hour liquid fast prior to surgery, it was found that liquid fasts lasted for an average of ten hours. Crenshaw and Winslow [2002] suggest that one reason why traditional practices continue, and current evidence based guidelines are not followed, is because of the concern about aspiration. However, Murphy *et al*, [2000] looked at two groups where they used the traditional methods of fasting for a fifteen week period followed by a liberalised regime of fasting for a further fifteen weeks. No differences in the incidence of aspiration were found in either group, in fact there was no incidence of aspiration in either group (total of 5,420 patients). Furthermore, clear gastric contents in the posterior pharynx were observed significantly more frequently in the traditional fasting group.

Another reason why current guidance is not followed is that the procedure may be performed earlier than expected if another procedure is finished early or cancelled, however Crenshaw and Winslow [2002] found no evidence to support this happening on a regular basis.

When writing my policy I looked at all points of view and decided that we were well placed to ensure that patients drank up to two hours prior to surgery. The process is going to start in preassessment where a plan will be developed with the patient to ensure that they understand both the importance of fasting and also the importance of taking fluid prior to surgery.

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Our patients will be admitted on the day of surgery, we will know where they are on the list so they will be given water to drink up to two hours prior to surgery. We will be dealing with an older client group and therefore it is important that they remain hydrated, and we are going to work hard to ensure this happens, and demonstrate that it is possible to follow current fasting guidelines.

Upon completion of this policy, I was pleased with it and cannot wait to put it into practice. The reason I am telling you this is that even with two jobs, I still have had time to reflect and develop my practice, something I consider important to the growth and development of nursing. You do not need to do anything as major as a policy change, you could just do something little that in some small way affects the treatment your patients receive, we are all capable of growth and development so go on give it a try, and if you do write to me and tell me about it and maybe we could put it in the journal, to share with other readers.

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