

Minimising the Risk of Litigation in Minor Surgery

CLINICAL RISK MANAGEMENT & BEST PRACTICE REFERENCE GUIDE

Status: Educational Practice Reference | Target Audience: GP Registrars, Practice Nurses & Primary Care Practitioners

DISCLAIMER: This document is provided exclusively for educational and training purposes as a teaching aid. It does not constitute formal clinical guidance. Practitioners must independently verify all medical information, protocols, and legal requirements against current guidelines from reputable UK surgical bodies, the GMC, and local integrated care board (ICB) policies before performing any clinical procedures.

1. Surgical Excisions & Incisions

- **Facial Surgery:** Surgery to the face carries significant cosmetic and functional risk. If in any doubt regarding diagnosis, margins, or technical complexity, the patient must be referred to a specialist.
- **Anatomical High-Risk Regions:** Particular care is required when operating on the shoulder, chest, and deltoid regions, as these are well-documented areas prone to developing hypertrophic or keloid scarring.
- **Scar Management:** Excision of an existing hypertrophied or keloid scar carries a very high recurrence rate and is best referred directly to a specialist.
- **Wound Care & Escalation:** Practice Nurses or assisting staff must always seek the urgent opinion of the operating GP or a designated clinical lead if a post-operative wound is not healing satisfactorily or shows signs of chronic breakdown.

Clinical Governance Requirement

It is mandatory to have a formally agreed, practice-wide clinical protocol covering all aspects of post-operative care, including specific timelines for suture removal based on anatomical site, and standardized patient advice pathways.

2. Documentation & Continuity of Care

- **Medical Records:** The complete structural state of the wound, anatomical site specifics, and the exact date/timing of suture removal must be contemporaneously documented in the patient's permanent electronic medical record.
- **Minor Surgery Register:** Maintenance of a central Minor Surgery Record Book (or integrated digital register) remains highly useful for tracking outcomes. This must capture: the operation performed, the exact batch/type of local anaesthetic and sutures used, mandatory histology tracking, and the incidence of any complications (e.g., secondary infection or haemorrhage).
- **Patient Safety Information:** Patients must be supplied with clear, written post-operative instructions before leaving the clinic. This must explicitly detail follow-up arrangements, care of the dressing, known potential complications, and specific emergency contact information.

3. Intra-Articular & Peri-Articular Injections

- **Aseptic Technique:** Full, strict aseptic precautions are mandatory for all joint and soft tissue infiltrations to mitigate the risk of iatrogenic septic arthritis.
- **Contraindicated Sites:** Never inject into or directly through clinically infected or compromised superficial tissue.
- **Neurovascular Safeguards:** Precise anatomical knowledge and localized landmarking are essential to avoid causing structural damage to adjacent neural or vascular complexes. If a patient experiences sudden paresthesia during needle advancement, immediately stop and withdraw.

URGENT ACTION Suspected Joint Infection

If a joint is suspected to be infected post-procedure, or presents with acute inflammatory features indicating septic arthritis, this constitutes a medical emergency. **Immediate, urgent same-day referral to an orthopaedic specialist or emergency department is mandatory.**

4. Chemical Cautery & Hazardous Substances

Chemical Agent	Mandatory Control Measures & Clinical Safety Rules
Phenol (e.g., Matricectomy)	<ul style="list-style-type: none">• Separation: Store phenol physically separated from lidocaine and skin cleansing agents to completely prevent accidental syringe-loading errors.• Operational Safety: Only open the bottle immediately when required. Ensure the nail bed/target tissue is dried thoroughly; moisture dilutes phenol and decreases its efficacy.• COSHH & Security: Return and secure phenol in a locked, chemical-safe cupboard immediately after use.
Silver Nitrate	<ul style="list-style-type: none">• Preparation: Apply an inert protective barrier jelly (such as petroleum jelly) or a barrier film to the surrounding healthy skin before application.• Application Control: Ensure that the activated silver nitrate tip touches <i>only</i> the target hypergranulation tissue or granuloma. Never allow contact with surrounding normal skin to avoid accidental chemical burns.• Clinical Note: UPDATED Activate the tip using sterile water or wound exudate. Do not use normal saline, as chloride ions will precipitate and inactivate the silver nitrate.

5. Physical Ablation: Cryotherapy & Electrocautery

- **Cryotherapy Exposure Constraints:** The cryoprobe/liquid nitrogen spray can cause severe blistering, deep tissue necrosis, and permanent scarring if left in contact with skin for extended periods. The standard recommended application time is **10–15 seconds max** per cycle, repeated at three-weekly intervals if clinically indicated.
- **Consent & Risk Disclosure:** Patients must be explicitly warned of the risk of permanent scarring, hypopigmentation, or blistering during the informed consent process, and this specific discussion must be documented in the medical records.
- **Electrocautery Volatiles Fire Risk:** **MODERN SAFETY STANDARD** **Spirit-based (alcohol) skin cleansers are strictly contraindicated** when undertaking electrocautery or hyfrecation due to the critical risk of surgical flash fires. Use aqueous chlorhexidine or alternative non-flammable solutions. Ensure any pooling of solution is dried completely before generating a spark.
- **Collateral Thermal Damage:** Extreme care must be taken during electrocautery to ensure the active tip does not accidentally make contact with surgical dressings, gauze swabs, or drape materials.