Surgery and Anaesthesia Preadmission Handbook

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Introduction

The careful preparation of patients for elective surgery is paramount in reducing the risk of preventable adverse peri-operative events and improving the safety of patients undergoing surgical procedures and anaesthesia.

Preadmission process initiatives were introduced in November 2004 as a result of reviewing peri-operative services across Austin Health. These changes were designed to improve the efficiency of our preadmission process.

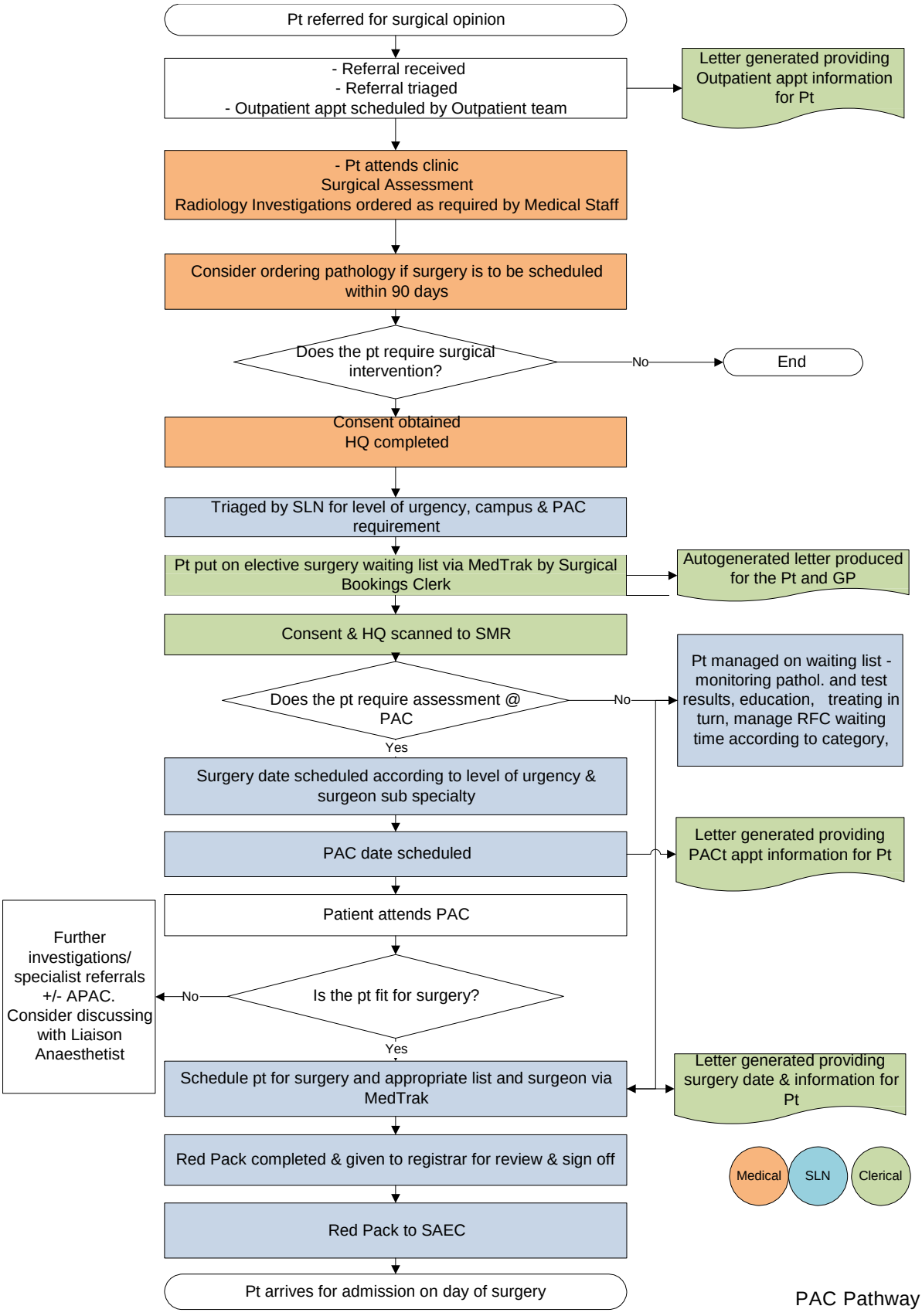
"Poor pre-operative evaluation continues to be the single most common contributory factor in anaesthetic mortality and morbidity in Victoria."
(Victorian Consultative council on Anaesthetic Mortality and Morbidity Information Bulletin, June 2002)

"The problem is not bad people in health care; its good people working in bad systems that need to be made safe"
(L.Kohn in "To err is human", 2000)

Further review of the preadmission service at Austin Health has ensued during 2012, and resulted in several recommendations for service improvements. Following further hospital consultation the proposed model was endorsed by the steering committee on 14th May 2013. This revised preadmission model is designed to ensure that all patients follow a standard pathway to determine if they are optimised for surgery, while recognising the specific requirements for different specialty groups. The model seeks to streamline the triage process with a focus on the complexity of the surgery and the patient's health status.

This handbook is intended to help guide all clinicians involved in the elective surgical patients' perioperative journey.

Defined Surgical Pathway



PAC Pathway

Pre Operative Investigations

This table is a **guideline** that assists in planning what preoperative investigations are required as a base work-up for the elective surgery patient. This will vary for individual patients depending on their co-morbidities and on information gained from the clinical history and examination.

It does not address the tests required for specific surgical procedures, which will depend on the nature of the surgical pathology and on the type of operation; you are strongly advised to refer to individual surgical handbooks/protocols for this information.

The role of preoperative testing is to assist in perioperative management and decision making. It should therefore be performed based on risk assessment – **a test done only if the results will effect patient treatment and outcomes.**

Preoperative testing can be guided by

- Nature of planned surgery
- Severity and stability of medical conditions
- Exercise tolerance
- Age

Asymptomatic patients

Day Stay	ECG	CXR	FBE	U&E	LFT	HbA1c
<40						
≥40 to <70						
≥70 to <80						
≥80	X					

1 Night Stay	ECG	CXR	FBE	U&E	Albumin	HbA1c
<40						
≥40 to <70	X		X	X		
≥70 to <80	X		X	X	X	X
≥80	X		X	X	X	X

> 1 Night Stay	ECG	CXR	FBE	U&E	LFT	Fe Studies / CRP	HbA1c
<40	X		X	X		X	X
≥40 to <70	X		X	X		X	X
≥70 to <80	X	X	X	X	X	X	X
≥80	X	X	X	X	X	X	X

Disease Related

Disease Specific	ECG	CXR	FBE	U&E	LFT	Coagulation Profile	Fe Studies / CRP	HbA1c
CVS	X	X	X	X				
RESPIRATORY	X	X	X	X				
LIVER			X	X	X	X		
RENAL			X	X				
BLEEDING/ANAEMIA			X	X		X	X	
DIABETES	X	X		X				X

Consent & Request for Patient Admission (M40.0)

Austin Health consent policy states:

It is the responsibility of the **senior medical officer in charge of providing care** to that patient **to oversee** that **valid informed consent for treatment is obtained and is documented**. The consultant in charge of a case is not necessarily responsible for personally obtaining consent and **may delegate** this to an appropriate member of the clinical team caring for the patient.

It is important that the obtaining of consent in a delegated manner is properly supervised and that the doctor obtaining consent is adequately supported with information.

Such delegation does not reduce the responsibility that attaches professionally and legally to the consultant in charge of the case.

With regard to junior medical staff and nurses obtaining consent, the principle is that informed consent can only be obtained by a person who is suitably skilled, competent and understands the nature of the intervention, the likelihood of harm and the degree of possible harm, is able to give information that the patient requires and is able to discuss alternate options for diagnosis and treatment.

For surgical procedures or higher-level procedures, the person performing the procedure (surgeon) or a person of equivalent status or knowledge (specialist surgical registrar) obtains the informed consent for the procedure, as they will be aware of all the complications and material risks associated with the procedure.

Junior Medical Staff below Registrar level and Nurses can only obtain informed consent for simple or low-level procedures that they perform (eg. Endoscopy, cystoscopy) and they are aware of all the complications and material risks associated with the procedure.

Many situations exist in which obtaining informed consent can be complex. There is a detailed hospital policy regarding informed consent located on the HUB. It contains very helpful information about obtaining consent, legal capacity to give consent, special consent situations, refusal of treatment, as well as useful contact numbers.

Consent Policy: http://hub/page/1132/consent

Consent & Request for Patient Admission Form M40.0

An accurately completed consent form and health questionnaire must be received by the elective surgery booking office to progress the patients' addition to the waiting list and appropriate triage.

Health Questionnaire (M12.1)

The Health Questionnaire facilitates obtaining accurate, up to date information regarding the patient's medical history, and needs to be completed in outpatients at the time the Consent and Request for Patient Admission (M 40.0) is generated. Having the health questionnaire done in real time will ensure timely and accurate completion, and allow for the immediate triage and commencement of the patient's elective surgical journey.

If the above scenario is not able to be facilitated, it is recommended that the patient complete the health questionnaire with the assistance of their General Practitioner to improve the accuracy of its content.

The information on the Health Questionnaire is required so the Surgical Liaison Nurse/Coordinator (SLN) can effectively commence the triage process.

Health Questionnaire Form M12.1

Triage of the Surgical Patient

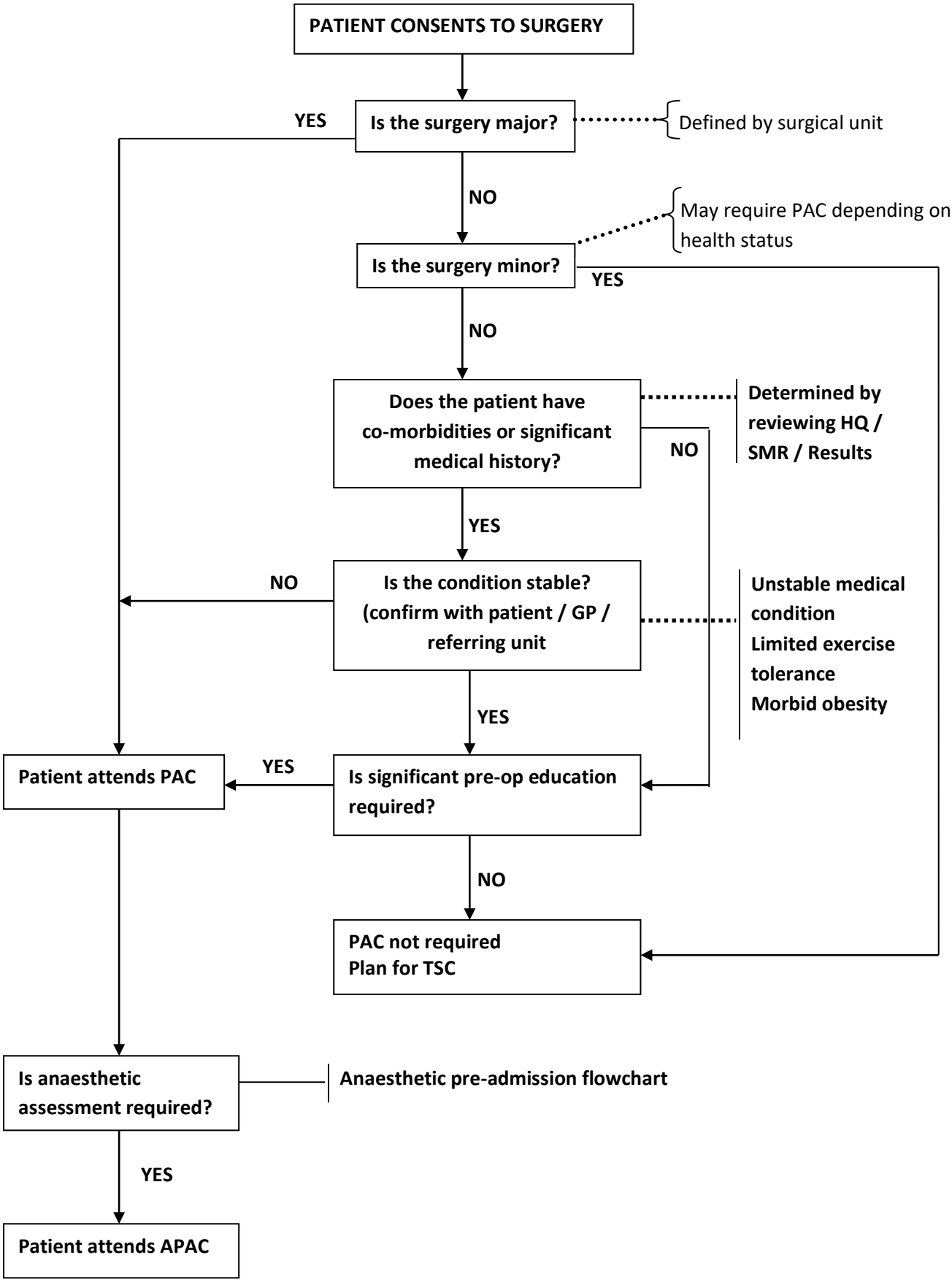
The SLN assesses, plans, implements and evaluates nursing care in collaboration with the patient and the multidisciplinary health care team so as to achieve goals and health outcomes.

Triage of the patient is the first stage in this process, and is undertaken by the SLN. Key components of the triage process involve review of the Health Questionnaire, Consent and Request for Patient Admission, patient's medical records and any further information obtained from general practitioners or specialist physicians.

Triage Principles Include:

- Nature of planned surgery
- Patients medical condition/optimisation of co-morbidities
- Patients exercise tolerance
- Age

The Surgery Centre patient selection guidelines


PATIENT CONSENTS TO SURGERY
Is the surgery major?
YES
Defined by surgical unit
NO
May require PAC depending on health status
Is the surgery minor?
YES
NO
Does the patient have co-morbidities or significant medical history?
Determined by reviewing HQ / SMR / Results
NO
YES
Is the condition stable? (confirm with patient / GP / referring unit
NO
Unstable medical condition
Limited exercise tolerance
Morbid obesity
YES
Patient attends PAC
YES
Is significant pre-op education required?
NO
PAC not required
Plan for TSC
Is anaesthetic assessment required?
Anaesthetic pre-admission flowchart
YES
Patient attends APAC

Does your patient require a Surgical Preadmission Assessment?

Use the following tool to ascertain if your patient requires a surgical preadmission assessment

Minor surgery ***Breast/Gen Surg 2*** eg. E/O Breast Lump, node biopsy ***Colorectal*** eg. EUA fistulas, haemorrhoids ***ENT*** eg. Tonsillectomy, EUA nose/ears, panendoscopy ***Neuro*** eg. CTR ***Orthopaedics*** eg. Arthroscopy, r/o metal ***Plastics*** eg. E/O BCC/skin lesions ***Urology*** eg. Rigid cysto ***Vascular*** eg. Varicose veins **Upper GI** eg. Laparoscopy, lap band port revision.	Unstable medical conditions for minor surgery may require surgical pre admission for patient optimisation (If unsure, please liaise with the ARNs)	**Proceed with planned surgery**
Intermediate Surgery ***Breast/Gen Surg 2*** eg. WLE & sentinel node bx. ***Colorectal*** eg. Closure ileostomy, rectopexy ***ENT*** eg. FESS, Mastoidectomy ***HPB*** eg. Lap chole, lap/open hernia repairs ***Neuro*** eg. Laminectomy ***Orthopaedics*** eg. ORIF, discetomy, scopes ***Plastics*** eg. Breast reduction, abdominoplasty ***Upper GI*** eg. Thyroid/parathyroid, lap splenectomy ***Urology*** eg. TURP ***Thoracic*** eg. Bronchoscopy, EBUS ***Vascular*** eg. Fem pop, carotid endarterectomy, endoluminal	New and / or unstable medical conditions Eg. angina, severe COAD, cardiac failure **Limited exercise tolerance** (unable to climb 2 flights of stairs) **Morbid Obesity** (BMI ≥ 40) **Complexity of Surgery**	**Patient will require Surgical Pre Admission** +/- Anaesthesia Pre Admission (If unsure, please liaise with the ARNs)
Major surgery ***Breast/Gen surg 2*** eg. Mastectomy & axillary clearance ***Cardiac*** eg. CABGS/Valve replacements ***ENT*** eg., Laryngectomy, Neck dissections ***HPB*** eg. Liver resection ***Neuro*** eg. Cranial sx ***Orthopaedics*** eg. Joint Replacement, spinal fusions. ***Plastics*** eg. D.I.E.P, lap doris flaps, Quad hands ***Thoracic*** eg. Thoracotomy, lobectomy, V.A.T.S ***Upper GI*** eg. Adrenal pancreatic & Gastric sx. ***Urology*** eg. Cystectomy ***Vascular*** eg. AAA repair ***Colorectal*** eg Bowel resections lap/open, Hartmanns		**Patient will require Surgical Pre Admission and referral to Anaesthesia Pre Admission**

The Surgical Preadmission Assessment information provided by the Surgical CSU Heads of Unit – See Appendix 3 – Surgical CSU Heads of Units

The Surgical Preadmission / Anaesthetic Referral Form (M11.9)

Why is it necessary?

Co-morbidities affect the surgical plan and/or the peri-operative outcome. Inter current medical problems may change the surgical plan. Often the pre-operative assessment will be the first general medical assessment the patient has had in many years.

New medical problems are often diagnosed for the first time, which have the potential to cause significant peri-operative or future morbidity/mortality if left untreated. The patient may require referral for appropriate assessment and ongoing management of these inter-current medical problems. E.g. An arrhythmia such as rapid atrial fibrillation noted on the ECG.

The results of tests ordered as a part of the pre-admission process **must** be reviewed by the surgical team. If the results are **abnormal**, appropriate action must be taken **before** the day of surgery and preferably before review in the anaesthetic clinic (unless an anaesthetic opinion is sought on the action required).

The members of the surgical and anaesthetic teams frequently change due to training rotations and schedule changes, so accurate and up to date documentation regarding the patient's clinical status and the surgical/anaesthetic plans has become critically important for providing safe care to surgical patients.

The pre-operative work-up of surgical patients is often complex due to the patients' co-morbidities and/or the nature of the planned surgery. Surgical preadmission clinics are often staffed by junior doctors with limited experience. Major reviews of peri-operative outcome such as the Victorian Consultative Council on Anaesthetic Mortality and Morbidity Information Bulletin, June 2002, and the UK National Confidential Enquiry into Peri-operative Deaths, have identified the need for senior medical supervision of the pre-admission process.

In recognition of this, at Austin Health, the Surgical Unit Registrar and/or Consultant must supervise the pre-admission process, review the paperwork and sign-off that each patient is ready for surgery.

Austin Health

Guide to completing the Surgical Preadmission Form M11.9

The M11.9 is to be used for ***all*** Surgical Unit pre-admission patients

Step 1 ***Resident Medical Officer***

- Complete pages 1, 2 & 3 at Preadmission, including "Surgical Preadmission Plan".
  Medical signature is required.
- In all cases, document the "Anaesthetic Referral" plan (**NO / YES)** and complete the associated referral if the answer is yes.
  Medical signature is required.

Step 2 ***Anaesthetist or Anaesthesia Resource Nurse (ARN)***

- Complete page 4 at the time of an Anaesthetic Consultation
  Medical signature is required or ARN signature in consultation with Anaesthetist.

Step 3 ***Surgical unit doctor or Surgical Liaison Nurse/Coordinator***

- Complete page 5, ensure all tests and referrals are documented and followed up as appropriate. Ensure "actions taken" for all abnormal results is complete.
  Medical sign off on all results is required.

Step 4 ***Surgical Registrar/Consultant***

- Complete final "sign off" section on bottom of page 5. This sign off indicates that the preadmission documentation (including test/referral results) has been reviewed and that the patient is either "Ready for Surgery" or is not proceeding with surgery (for documented reason).
  Medical sign off at Registrar/Consultant level is required.

Surgical Preadmission / Anaesthetic Referral Form M11.9

Operating Suite Passport (M41.0)

Purpose

All patients entering the Operating Suite for surgical/interventional procedures will have a completed Operating Suite Passport. A patient will not be accepted for a procedure or anaesthetic within the Operating Suite if the Passport is incomplete (time critical emergencies accepted).

All patients will be identified and admitted safely to the Operating Suite having had appropriate preparation for surgery. Proposed surgery is checked against the consent (M40.0) and the patient has understood the information given in regard to the proposed treatment.

All documentation relevant to the patient's admission to the Operating Suite is up to date and present. Patient clothing and valuables are accounted for and secured appropriately.

Elective Admission Pathway (via preadmission)

The patient is either admitted through the Surgery and Endoscopy Centre (SAEC) or The Surgery Centre (TSC). The liaison nurse/coordinator will complete and sign the ***"Outpatient Dept or ward or ED"*** section of the Operating Suite Passport preoperatively for elective patients.

During the patient's admission into SAEC or TSC, the admitting nurse will prepare the patient using the ***"Preoperative ward: Day of Surgery (ward staff)"*** section of the operating suite passport. When the patient's preparation for the Operating Suite is complete, the nurse will sign the bottom of the passport.

The anaesthesia/foyer nurse responsible for admitting the patient into the operating suite will then complete and sign the ***"Preoperative ward: Day of Surgery (Opsuite Staff)"*** section of the Operating Suite Passport with the patient, and when complete sign the bottom of the form.

In-patient Pathway

When the patient is admitted from ward areas including ED and ICU (elective and non-elective), the ***"Outpatient Dept or ward or ED"*** section is required to be performed preoperatively. This may be completed anytime following the patient admission to the ward.

The ***"Preoperative ward: Day of Surgery (ward staff)"*** section must be completed on the day of surgery prior to the patient leaving the ward area for transport to the Operating Suite and the ward nurse is required to sign the bottom of the passport.

Upon the patient's arrival at the Operating Suite foyer, the foyer nurse admitting the patient will complete and sign the ***"Preoperative ward: Day of Surgery (Opsuite Staff)"*** section of the Operating Suite Passport.

http://eppic/Document/10442

Operating Suite Passport Form M41.0

Blood Transfusion (M109.0)

It is a requirement that the Blood Transfusion (M109.0) consent is completed during the surgical pre admission by an attending medical officer for any patient who is at risk of requiring a blood transfusion during their elective surgical admission (if a Group and Screen is requested/collected, the M109.0 consent needs to complete). The medical officer is required to provide the patient with information about the risks and benefits of transfusion.

Refusal of medical treatment

Some patients refuse blood and blood products, in particular, Jehovah's Witnesses have specific religious beliefs regarding transfusion and their acceptance of particular products may vary (e.g. Albumin may be acceptable). A fully informed, competent adult patient is entitled to decide to accept medical treatment or not. Currently Jehovah's Witnesses are not identified on the hospital patient label and there is no alert on Medtrak or Cerner to remind staff of their religious status.

Jehovah's Witnesses carry an ***"Advance Health Care Directive"*** card that alerts staff of their beliefs and therefore restrictions to treatment that can be administered. This is an entirely separate document to the ***"Refusal of Treatment Certificate"*** and has no legal validity under the Medical Treatment Act.

In the case of an **adult** patient, the patient should be requested to complete and sign a ***"REFUSAL OF TREATMENT"*** certificate. This certificate provides the hospital and its staff with legal protection (not necessarily available from relying on an advance **directive**).

http://eppic/Document/1696

Blood Transfusion Form M109.0

Refusal of Treatment – Competent Person Form L5.0

Resuscitation Plan (L0.5)

The Resuscitation Plan should be completed on all Austin Health inpatients for whom there is a *reasonable* risk that a Code Blue or MET call may be required during their inpatient stay. This includes the following patients:

- ***those over the age of 75*** ;
- those with significant neurological, cardiac or respiratory failure;
- those on dialysis AND with higher risk of cardio-respiratory arrest and/or of those
- with significant co morbidities ;
- those with advanced dementia ;
- those with advanced malignancy (metastatic disease with end-organ failure)
- those with conditions determined by individual unit policy.

Patients admitted for day admissions, i.e. day oncology***, day surgery***, are exempt from the completion of the Resuscitation Plan for each admission episode. The treating medical consultant may consider that it is still appropriate to complete a form for these patients. In these cases, the Resuscitation Plan should be reviewed every three months, or if there is a significant change in the patient's medical condition.

Once the L0.5 is completed the order will need to be placed in Cerner by a Medical Officer. The patient Resuscitation plan and Advanced Care Directive (ACD) will display on the patients Yellow Banner Bar.

http://eppic/Document/1345

Resuscitation Plan Form L0.5

Guidelines for the Pre-Operative Medical Assessment and Anaesthetic Referral

This section is a guideline only, ***not*** a protocol; it is aimed ***only*** at the assessment of **ELECTIVE** surgical patients.

These guidelines do ***not*** address surgical assessment or discussion of surgical risk (such information should be obtained through the Department of Surgery).

Principles

Only common and/or important, examples of clinical problems are addressed. There will be many patients with rare and/or severe disease states which are not specifically covered. Please consider discussing these patients with either the Anaesthesia Resource Nurses (ext 4715, 4717 or pg 1232, 1283) or liaison Anaesthetists specific for your unit through the Department of Anaesthesia (ext. 5704) for further advice.

Pre-operative medical assessment should be based around the following;

The Completed Health Questionnaire

The clinical history and examination

The patients exercise tolerance

The ASA Status **(See Appendix 2)**

The surgical pathology

The planned operation

New Medical Problems

The pre-operative assessment should be considered an **opportunity** to identify significant medical problems (particularly cardiac and respiratory disease), which **may not** have previously been diagnosed but which have the potential to cause significant peri-operative or future morbidity or even mortality if left untreated.

Often the preoperative assessment will be the first general medical assessment the patient has had in years. New medical problems may be diagnosed for the first time, and the patient may need to be referred for appropriate assessment and ongoing management of newly diagnosed or worsening medical conditions.

Test Results

All test results **must** be reviewed by the surgical team and appropriate action taken if results are abnormal, **before** the day of surgery, and preferably before review in the anaesthetic clinic.

This is important because;

The abnormal test result may change the surgical plan.

The Anaesthetic Clinic appointment may not be for several weeks, whilst the abnormal result may require more urgent intervention/investigation in the interim.

There are medico-legal risks associated with failing to follow-up abnormal test results.

Documentation of all preadmission test results on page 5 of the preadmission form will communicate to all staff involved in the patient's care that the results have been reviewed and what action has been taken for any abnormal results. There are frequently changes in the teams caring for patients, and test results are no longer printed out by the laboratories. This means that documentation of test results and of action taken for abnormal results on the preadmission form is a critical part of the preadmission process.

Indications for Anaesthetic Referral

Examples only, **NOT** a complete list, if you are uncertain please contact the Anaesthesia Resource Nurses (ext 4715, 4717 or pg 1232, 1283) or liaison Anaesthetists specific for your unit for further advice. The Surgical Liaison anaesthetist list can be found through the below link.

http://hub/Assets/Files/Administration%20Handbook%202013.pdf (see page 10.)

PATIENT REQUEST	• **Any** patient who requests to talk to an anaesthetist before the day of surgery, **all patients should be offered this opportunity**	
SURGICAL FACTORS	**ANY MAJOR SURGERY** • For adequate discussion of Anaesthetic risks and procedures. • Patients undergoing major surgery are likely to have questions/concerns regarding the anaesthetic. • Even stable medical problems may have significance.	• Intra-thoracic procedures • Oesophagectomy • Major airway surgery/maxillofacial surgery • Major ENT surgery • Thyroidectomy • Open intra-abdominal procedures • Hepatic surgery • Abdominal Aortic Aneurysm repair • Peripheral vascular surgery • CABG / Cardiac surgery • Joint replacement surgery • Spinal surgery • Craniotomy • Major Gynaecology procedures • Major plastic surgery
PATIENT FACTORS	**PREVIOUS ANAESTHETIC PROBLEMS**	• Past/family history of Malignant Hyperthermia (known/suspected) • Anaphylaxis/significant allergic reaction • Airway complication • Intra-operative/peri-operative cardiac arrest or cardiac event • Awareness
	MULTIPLE/SEVERE MEDICAL PROBLEMS	• Anaesthetist requires adequate **time** to evaluate the patient pre-operatively, and to arrange further work-up if needed. This is not possible if the patient is only seen by the anaesthetist on the day of surgery.
	MORBID OBESITY	• Significant ↑ peri-operative risks
	SEVERE OBSTRUCTIVE / CENTRAL SLEEP APNOEA	• Remind patient to bring CPAP machine on day of admission • May have secondary pulmonary hypertension / right heart failure

References

Victorian Consultative Council on Anaesthetic Mortality and Morbidity Information Bulletin, June 2002

Report of the National Confidential Enquiry into Peri-Operative Deaths (CEPOD - UK), 2002

Preoperative tests; the use of routine preoperative tests for elective surgery, National Institute for Clinical Excellence, NHS, June 2003

Surgical Services; review of booking process, Austin Health, Bettina Lijovic, July 2010

ePPIC - electronic Policies, Procedures, Information for Consumers & Cerner Care Sets, Austin HUB

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Appendix 1 – Hyperlinks to Forms

Consent & Request for Patient Admission Form M40.0

Health Questionnaire Form M12.1

Surgical Preadmission / Anaesthetic Referral Form M11.9

Operating Suite Passport Form M41.0

Refusal of Treatment – Competent Person Form L5.0

Resuscitation Plan Form L0.5

Appendix 2 – The ASA Status (American Society of Anaesthesiologists Physical Status Classification)

ASA 1	Healthy patient with no medical problems
ASA 2	Mild systemic disease, e.g. Controlled hypertension, mild controlled asthma
ASA 3	Significant but not incapacitating systemic disease, e.g. Stable IHD, controlled CCF, COAD, morbid obesity
ASA 4	Severe systemic disease that is a constant threat to life, e.g. Severe COAD, LVF, unstable angina

Appendix 3 – Heads of Units contributing to Preadmission Assessment Tool

Caroline Baker	Breast
Assoc. Prof. George Matalanis	Cardiac
Matthew Campbell	Ear, Nose, Throat, Head & Neck
Adele Burgess	Colorectal
Prof. Robert Jones	Hepatobiliary & transplant
Gus Gonzalvo	Neurosurgery
Andrew Hardidge	Orthopaedics
Steve Flood	Plastics
Simon Knight	Thoracics
Ahmed Aly	Upper G.I & Endocrinology
Damien Bolton	Urology
Gary Fell	Vascular

Appendix 4 – Liaison Nurse Contact details

Liaison Nurse Contact List

Appendix 5 – The Surgery Centre patient selection guidelines

- Planned surgical procedure fits within the guidelines as suitable for TSC
- All patients for both TSC and AOS **must** have a completed Pre-admission Health Questionnaire M12.1
- ASA I and II
- ASA III after TSC Anaesthesia Pre-admission Clinic (TSC APAC) assessment for suitability for TSC. (ASA III patients requiring endoscopy or LA/Sedation **only** do not need to attend TSC APAC)
- If BMI >35 → <45, must attend TSC APAC for assessment of suitability for TSC
    - **OHS Consideration only** maximum weight 130Kg
- OSA or suspected OSA after TSC APAC assessment for suitability for TSC
- Stable, independent patients with paraplegia from spinal cord injury (quadriplegia is contra-indicated)
- Patients ≥4 years of age, except Myringotomy and tubes in which >2 years is acceptable
- History of anaesthesia problems including difficult airway after TSC APAC assessment for suitability for TSC