**Guideline**

# The Perioperative Toolkit

**Summary** The Perioperative Toolkit is designed to aid in the continuous quality improvement of perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia. The Perioperative Toolkit applies evidence and clinical reasoning to risk stratification and directing resources to clinical need. The nine elements of perioperative care described in this Toolkit build upon the five in its predecessor – the Pre Procedure Preparation Toolkit (PPPT) (2007).

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**Audience** Clinical, Allied health, Operating theatres, Pre-procedure clinics, Administration nursing, Medical

NSW GOVERNMENT Health

GUIDELINE SUMMARY

# THE PERIOPERATIVE TOOLKIT

The Perioperative Toolkit is designed to aid in the continuous quality improvement of perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia. The Perioperative Toolkit applies evidence and clinical reasoning to risk stratification and directing resources to clinical need.

Shared decision making with patients, families and carers and integration with primary care are integral aspects of perioperative care.

The nine elements of perioperative care described in this Toolkit build upon the five in its predecessor – the Pre Procedure Preparation Toolkit (PPPT) (2007).

## KEY PRINCIPLES

The perioperative team comprises of the patient, their family and carers, general practitioners, surgeons, proceduralists, anaesthetists, nurses, administrative and clerical staff, allied health professionals, primary healthcare providers, Aboriginal health, multicultural and diversity health workers.

The Perioperative Toolkit (2016) builds on the state-wide systems of the PPPT (2007). Significant inroads have been made in addressing elective surgery waiting times by reducing length of hospital stay in healthier patients having less major surgery.

The four new elements are directed towards measuring outcomes for quality improvement, pre-operative pre-habilitation and strengthening intra- and post-operative care for the high-risk complex patient with chronic multisystem disease having moderate to major surgery.

**Recommendations for prioritising perioperative care**

| **Standard care** | **Best practice (to be developed further over the next five years)** |
|---|---|
| **Elements 1,2,3,4,9** | **Elements 5,6,7,8** |

Effective perioperative care is reliant on the following key elements.

1. The perioperative process prepares the patient, family and carer for the whole surgical/procedural journey.
2. All patients require pre admission review using a triage process.
3. Pre procedure preparation (PPP) optimises and supports management of the patient's perioperative risks associated with their planned surgery/procedure and anaesthesia.
4. The multidisciplinary team collects, analyses, integrates and communicates information to optimise patient centred care.
5. Each patient's individual journey should follow a planned standardised perioperative pathway.

6. Measurement for quality improvement, benchmarking and reporting should be embedded in the perioperative process.
7. Integration with primary care optimises the patient's perioperative wellbeing.
8. Partnering with patients, families and carers optimises shared decision making for the whole perioperative journey.
9. Effective clinical and corporate governance underpins the perioperative process.

A range of tools are available on the Perioperative Toolkit page on the ACI website. These tools can be used and adapted to meet local needs.

## USE OF THE GUIDELINE

To address the economic challenges of safe access to elective surgery each NSW Health facility should have an integrated service in place for perioperative care and invest in strengthening the model of care.

The perioperative service should be supported and led by a clinical champion. Ideally the medical clinical leader or Director, Perioperative Service is an anaesthetist. An anaesthetist's continuing professional development and experience with surgeons and proceduralists at the most critical time of treatment, informs this role.

The medical clinical leader, collaborating closely with the nurse clinical leader, is responsible for:

- facilitating the other's leadership role
- the coordination of integrated perioperative multidisciplinary care
- the identification, communication and management of perioperative patient risk
- the establishment of local guidelines
- measurement, benchmarking and reporting of outcomes.

## REVISION HISTORY

| Version | Approved by | Amendment notes |
|---|---|---|
| November 2007 (GL2007_018) | Deputy Secretary, System Purchasing and Performance | First edition. |
| February 2018 (GL2018_004) | Deputy Secretary, System Purchasing and Performance | Addition of 4 elements of care that exemplify best practice for the perioperative patient. |

## ATTACHMENTS

1. The Perioperative Toolkit

ACI NSW Agency for Clinical Innovation

TOOLKIT

# The Perioperative Toolkit

Anaesthesia Perioperative Care Network
Surgical Services Taskforce

Collaboration. Innovation. Better Healthcare.

The Agency for Clinical Innovation (ACI) works with clinicians, consumers and managers to design and promote better healthcare for NSW. It does this by:

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- *specialist advice on healthcare innovation* – advising on the development, evaluation and adoption of healthcare innovations from optimal use through to disinvestment
- *initiatives including guidelines and models of care* – developing a range of evidence-based healthcare improvement initiatives to benefit the NSW health system
- *implementation support* – working with ACI Networks, consumers and healthcare providers to assist delivery of healthcare innovations into practice across metropolitan and rural NSW
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# Acknowledgements

The Perioperative Toolkit was first developed in 2007 as the Pre Procedure Preparation Toolkit by a working party commissioned by the Surgical Services Taskforce. The Agency for Clinical Innovation (ACI) would like to acknowledge the contribution of the 2015/16 working group – comprised of members of the Anaesthesia Perioperative Care Network, the Surgical Services Taskforce and the NSW Ministry of Health – in revising this Toolkit:

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The Chairperson and the ACI would also like to acknowledge:

- Ms Nicola Timmiss – NUM Perioperative Unit, Prince of Wales Hospital

# Glossary

| | |
|---|---|
| ACC | American College of Cardiologists |
| ACCHS | Aboriginal Community Controlled Health Service |
| ACI | NSW Agency for Clinical Innovation |
| AHA | American Health Association |
| AMS | Aboriginal Medical Service |
| ASA PS | American Society Anesthesiologists Physical Status Classification |
| BGL | Blood Glucose Level |
| BMI | Body Mass Index |
| CEC | Clinical Excellence Commission |
| CMP | Calcium, Magnesium and Phosphate |
| CPAP | Continuous positive airway pressure |
| CNC | Clinical Nurse Consultant |
| COU | Close Observation Unit |
| CP | Clinical Pathway |
| CXR | Chest X-ray |
| DOS | Day Only Surgery |
| DOSA | Day of Surgery Admission |
| ECG | Electrocardiogram |
| EDO | Extended Day Only |
| ENT | Ear, Nose and Throat |
| ER | Enhanced Recovery |
| EUC | Electrolytes, Urea and Creatinine |
| FBC | Full Blood Count |
| GP | General Practitioner |
| HDU | High Dependency Unit |
| HVSSS | High Volume Short Stay Surgery |
| ICU | Intensive Care Unit |
| LHD | Local Health District |
| MACE | Major adverse cardiac event |
| NSQIP | National Surgical Quality Improvement Program |
| NSW | New South Wales |
| OT | Operating Theatres |
| PAC | Pre Admission Clinic |
| PDSA | Plan Do Study Act |
| PHQ | Patient Health Questionnaire |
| PPP | Pre Procedure Preparation |
| PPPT | Pre Procedure Preparation Toolkit |
| RFA | Recommendation for Admission |
| RN | Registered Nurse |
| RRT | Rapid Response Team |
| SPP | Standardised Perioperative Pathway |
| TCPQ | Transfer of Care from hospital Planning Questionnaire |

ASA Physical Status Classification

- ASA 1 – A normal healthy patient
- ASA 2 – A patient with mild systemic disease
- ASA 3 – A patient with severe systemic disease
- ASA 4 – A patient with severe systemic disease that is a constant threat to life
- ASA 5 – A moribund patient who is not expected to survive without the operation

# Executive summary

The Perioperative Toolkit is designed to aid in the continuous quality improvement of perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia. This is achieved by facilitating effective knowledge sharing between key members of the multidisciplinary perioperative team for patient centred care. The perioperative team comprises – the patient, their family and carers, general practitioners, surgeons, proceduralists, anaesthetists, nurses, administrative and clerical staff, allied health professionals, primary healthcare providers, Aboriginal health, multicultural and diversity health workers. The Perioperative Toolkit applies evidence and clinical reasoning to risk stratification and directing resources to clinical need. The patient's underlying medical health status and social circumstances are taken into consideration alongside the impact of the intended surgery/procedure and anaesthesia. Shared decision making with patients, families and carers and integration with primary care are integral aspects of perioperative care.

### Elements of perioperative care

The nine elements of perioperative care described in this Toolkit build upon the five in its predecessor – the Pre Procedure Preparation Toolkit (PPPT) (2007). The method used by the expert Working Group was the Delphi technique[1] working with nascent international and local evidence, in particular peer reviewed empirical papers and models of care[2,3,4].

Effective perioperative care is reliant on the following key elements.

1. The perioperative process prepares the patient, family and carer for the whole surgical/procedural journey.
2. All patients require pre admission review using a triage process.
3. Pre procedure preparation (PPP) optimises and supports management of the patient's perioperative risks associated with their planned surgery/procedure and anaesthesia.
4. The multidisciplinary team collects, analyses, integrates and communicates information to optimise patient centred care.
5. Each patient's individual journey should follow a planned standardised perioperative pathway.
6. Measurement for quality improvement, benchmarking and reporting should be embedded in the perioperative process.
7. Integration with primary care optimises the patient's perioperative wellbeing.
8. Partnering with patients, families and carers optimises shared decision making for the whole perioperative journey.
9. Effective clinical and corporate governance underpins the perioperative process.

| **Recommendations for prioritising perioperative care** | |
|---|---|
| Standard care | Best practice<br>(to be developed further over the next five years) |
| Elements 1,2,3,4,9 | Elements 5,6,7,8 |

The Perioperative Toolkit (2016) builds on the state-wide systems of the PPPT (2007). Significant inroads have been made in addressing elective surgery waiting times by reducing length of

hospital stay in healthier patients having less major surgery. The four new elements are directed towards measuring outcomes for quality improvement, pre operative prehabilitation and strengthening intra- and post-operative care for the high-risk complex patient with chronic multisystem disease having moderate to major surgery.

### Tools

The following tools aid the perioperative team members to perform their roles.

- Recommendation for Admission Form (RFA)
- Patient Health Questionnaire (PHQ) – Adult – Appendix 1
- Patient Health Questionnaire (PHQ) – Paediatric – Appendix 2
- Transfer of Care from Hospital Planning Questionnaire (TCPQ) – Appendix 3
- Conditions/considerations for assessing a patient's perioperative risk – Appendix 4
- Additional Information to be obtained from the Primary healthcare provider – Appendix 5
- Pre Admission Medical Anaesthetic Assessment Form – Appendix 6
- Perioperative patient information booklet (PPIB) – Appendix 7
- Patient information checklist – Appendix 8
- Standardised Perioperative Pathway (SPP) – Appendix 9
- Enhanced Recovery or Clinical Pathways for specific surgical procedures

A range of tools, including the above Appendices, are available on the Perioperative Toolkit page on the ACI website. These tools can be used and adapted to meet local needs.

### Key roles and governance

To address the economic challenges of safe access to elective surgery each NSW Health facility should have an integrated service in place for perioperative care and invest in strengthening the model of care. The perioperative service should be supported and led by a clinical champion. Ideally the medical clinical leader or Director, Perioperative Service is an anaesthetist. An anaesthetist's continuing professional development and experience with surgeons and proceduralists at the most critical time of treatment, informs this role.

The medical clinical leader, collaborating closely with the nurse clinical leader, is responsible for:

- facilitating the other's leadership role
- the coordination of integrated perioperative multidisciplinary care
- the identification, communication and management of perioperative patient risk
- the establishment of local guidelines
- measurement, benchmarking and reporting of outcomes.

# Contents

## Introduction

In 2007, the Surgical Services Taskforce commissioned a Working Group to develop the Pre Procedure Preparation Toolkit (GL2007_018). Updating the previous guideline in 2015-2016, the NSW Agency for Clinical Innovation (ACI) Anaesthesia Perioperative Care Network in collaboration with the Surgical Services Taskforce and the Ministry of Health present the Perioperative Toolkit (the Toolkit). The evidence based Toolkit is designed to aid in further developing perioperative structures, processes and outcomes for patients having a surgery/procedure and anaesthesia. This is achieved by facilitating knowledge sharing between key members of the multidisciplinary perioperative team for patient centred care. The Toolkit applies evidence and clinical reasoning to risk stratification and directing resources to clinical need. The patient's underlying medical health status and social circumstances are taken into consideration alongside the impact of the intended surgery/procedure and anaesthesia. Shared decision making with patients, families and carers and integration with primary care are integral aspects of perioperative care.

This Toolkit was prepared and has been reviewed by frontline clinicians and staff experienced in perioperative care, including anaesthetists, surgeons, nurses, allied health professionals, consumers, managers and primary healthcare providers. The Toolkit has taken into account best practice guidelines described in Australian and international literature[2,3,5].

## Scope of application for this Toolkit

The patient's surgical/procedural journey begins with the patient at home and ends when the patient is safely returned to their place of residence. One of the main functions of a Perioperative Service is to ensure that the patient is optimally prepared for their complete surgical/procedural journey and that this occurs in a safe, efficient and patient-centred manner. The principles outlined in the Toolkit are applicable for both adult and paediatric patients.

It is important that perioperative care is delivered in culturally safe and competent ways. To overcome the evolving barriers to lifelong care that Aboriginal people may experience, Perioperative Services need to work in partnership with Aboriginal health care providers to tailor care to achieve optimal perioperative health outcomes. In particular, this should include a demonstrated commitment to building trust with Aboriginal people to ensure assessment, planning, referral and follow up processes are tailored to the individual. This approach should also take account of the holistic approach to health that is shared by most Aboriginal people and communities and identify key services and staff who can support these processes to achieve optimal health outcomes for Aboriginal people undergoing surgery/procedure.

While the Toolkit is predominantly focussed on the elective patient undergoing surgery/procedure, many of the elements outlined in the document also apply for patients undergoing an emergency surgery/procedure. Emergency surgery is a major component of the surgical services workload in many NSW hospitals. The Emergency Surgery Guidelines provide the principles to be applied to emergency surgery in NSW public hospitals[6].

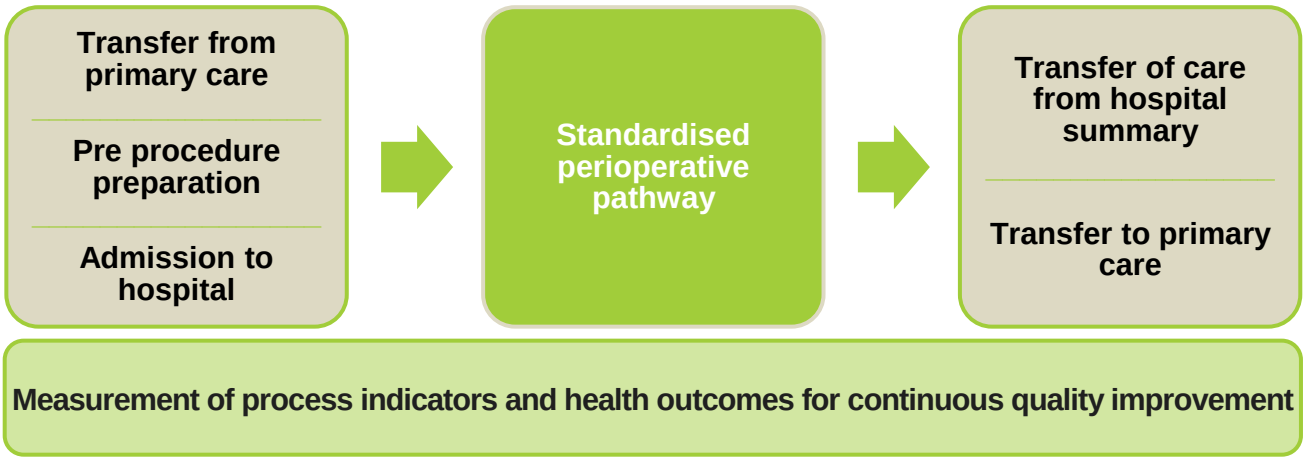
The perioperative process is the framework of systems, tools and multidisciplinary teams that is essential in ensuring a successful surgical/procedural journey. It is applicable for all NSW public health institutions – including tertiary, metropolitan, regional and rural facilities. Each NSW health facility undertaking surgery/procedures must have an effective integrated service framework in place to support the perioperative process.

## Step by step guide to perioperative care

### Element 1: The perioperative process prepares the patient, family and carer for the whole surgical/procedural journey

The patient's surgical/procedural journey begins at home and ends when the patient is safely returned to their home or place of residence. The Perioperative Service is responsible for as many phases of this journey as possible, from pre procedure preparation (PPP) to transfer of care from hospital. Having one service ensures that processes are well integrated and protocols are developed in a cohesive manner.

**Diagram 1: The perioperative process**




The perioperative process optimises the surgical/procedural journey for every patient by collating, analysing, integrating and communicating information from multiple sources. The aim is to make each individual patient's experience safe, appropriate, effective, efficient and positive.

The risk stratification process that underpins this Toolkit considers the patient's underlying medical health status and social circumstances alongside the impact of the intended surgery/procedure. Patients may then be effectively and efficiently allocated to: pre admission clinics (PAC), day of surgery admission (DOSA), day only surgery (DOS), extended day only surgery (EDO) or several days stay in the hospital ward, high dependency unit (HDU) – increasingly known in NSW as Close Observation Units (COU) – the intensive care unit (ICU) and sub-acute services such as rehabilitation. High Volume Short Stay Surgical (HVSSS) wards are dedicated areas that look after surgical DOS and EDO admissions as well as hospital stays up to 72 hours. Some of these – for example EDO[7] and HVSSS[8]– have specific NSW Health guidelines. Planning for transfer of care from hospital back to primary care similarly triages community resources to patient need.

#### 1.1 Health and social summary for the surgery/procedure

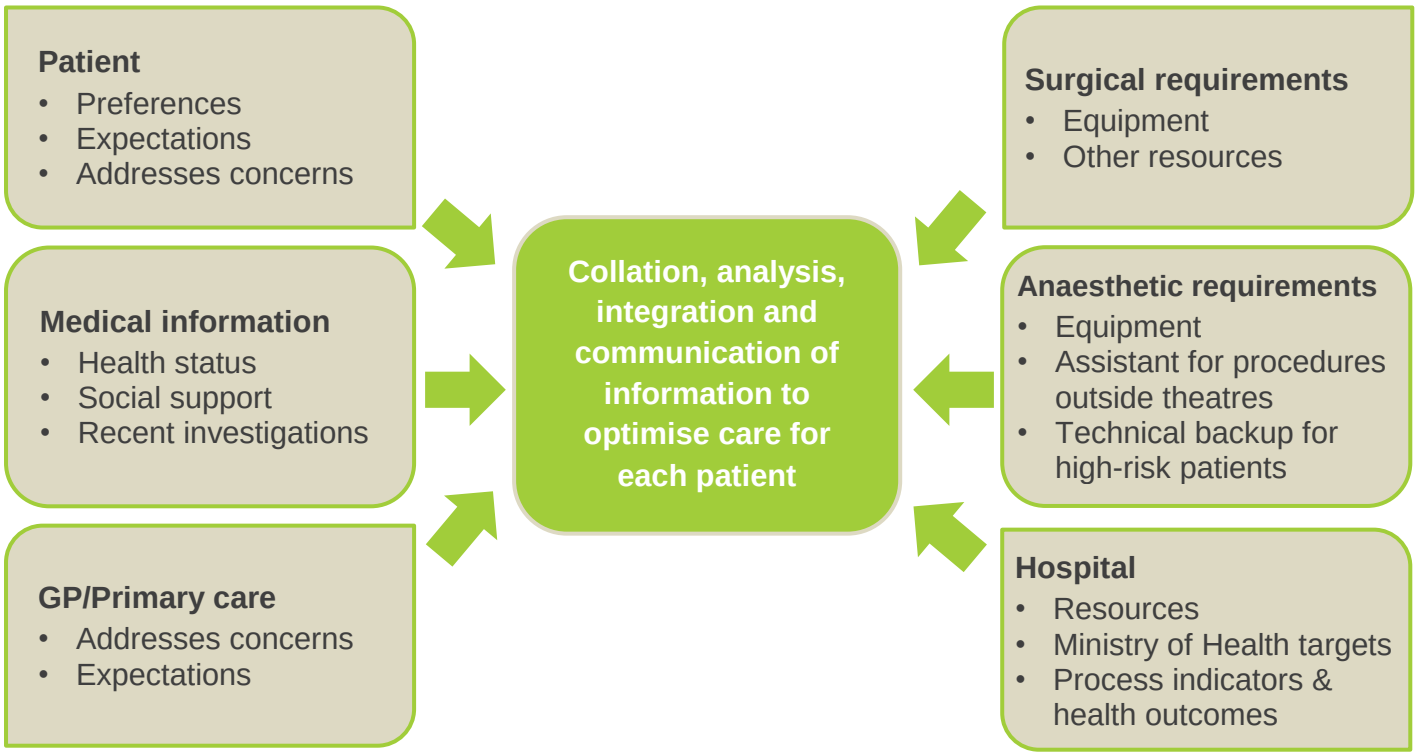
The patient's health and social status, along with the details of the surgery/procedure/anaesthesia and plan of care at finalisation of PPP should be documented and dated in a consistent format and readily available to all health professionals caring for the patient.

The detail of the health summary and surgical/procedural information will be influenced by the complexity of both the patient's health and social status and the risks of the planned surgery/procedure. Where possible, the summary should increasingly be part of the hospital's

electronic record system. These records lay the foundation for the care that will be delivered by staff before, during and after the surgery/procedure and anaesthesia and should be further updated with the patient's perioperative progress and recovery.

**Diagram 2: What does perioperative care deliver?**

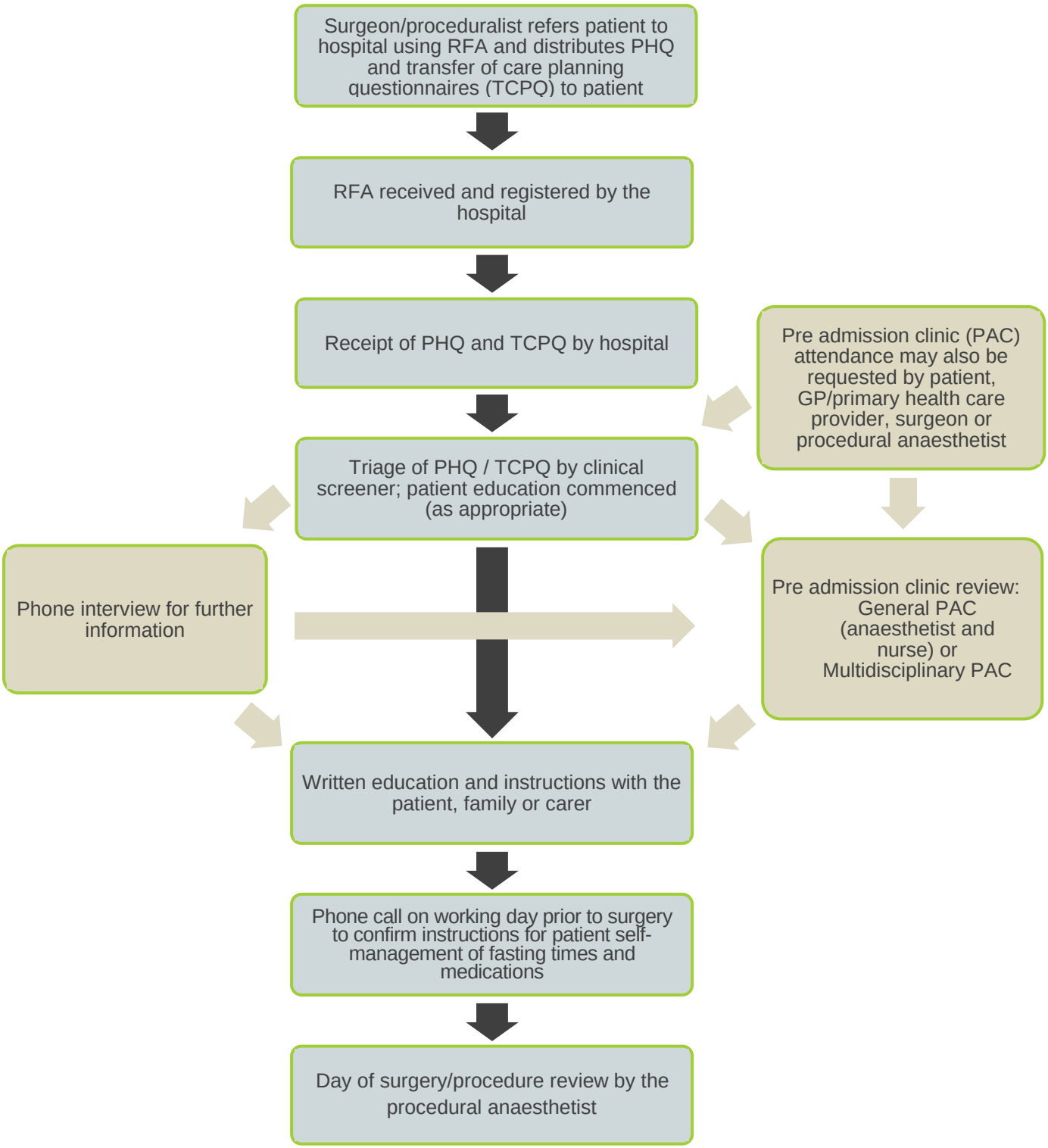
***Perioperative care delivers knowledge sharing to support patient centred care.***



## Element 2: All patients require pre admission review using a triage process

All patients require pre admission review using a Patient Health Questionnaire (PHQ) and Transfer of Care from hospital Planning Questionnaire (TCPQ) triage process but not all patients need investigations or to attend a PAC. Using a triage process has been the practice of Perioperative Services in many hospitals across NSW for the last 15-20 years. Internationally the practice is also well established. The triage questionnaires have been updated for increased sensitivity to frailty, cognitive decline, delirium, behavioural issues and other more prevalent conditions such as obstructive sleep apnoea and chronic pain.

**Diagram 3: The triage process**



A triage process:

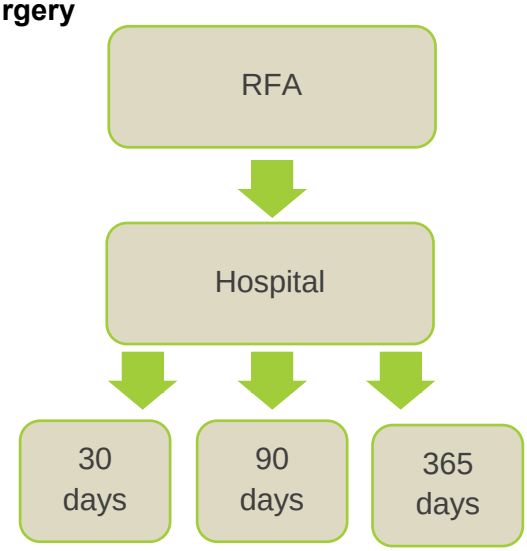
- avoids duplication and unnecessary investigations
- matches resources to the impact or complexity of the surgery/procedure and the patient's medical needs
- assists in perioperative planning and determining whether additional investigations or processes are needed based on the patient's level of medical and surgical risk.

Triage criteria and processes must also include any non-medical needs of the patient, including professional interpreter services, Aboriginal hospital liaison services, multicultural or diversity health services, patients with a disability and patients who are carers for others.

### 2.1 Recommendation for admission

The surgeon/proceduralist refers the patient to the hospital's Perioperative Service by completing the Recommendation for Admission (RFA) and consent form and distributes the PHQ and TCPQ to the patient and carer. The RFA must include the minimum information outlined in the NSW Health Waiting Time and Elective Surgery Policy[9].

**Diagram 4: Time to surgery**




### 2.2 PHQ review and triage

Screening for triage should be undertaken by an appropriately trained health professional, e.g. a nurse, anaesthetist, general practitioner (GP) or surgeon, ideally within two working days of receiving the PHQ. The RFA will indicate clinical priority category, nature and complexity of the surgery/procedure and may include the scheduled or anticipated date for the surgery/procedure and length of stay. The triage process should be completed at least two to four weeks prior to surgery. In some circumstances – for example patients with complex chronic multisystem disease and over 70 years old having more than minor DOS – PHQ and TCPQ review may be necessary several months prior to the surgery/procedure for collaborative prehabilitation in primary care. See Element 7.

A PHQ is the foundational tool for pre admission triage. Examples of these tools: PHQ – Adult (Appendix 1) and PHQ – Paediatric (Appendix 2) are available in the appendices or on the Perioperative Toolkit page on the ACI website and can be adapted to meet local needs. The information provides the necessary detail for the screener to make a decision regarding the level of

further assessment required. See also Conditions/considerations for assessing a patient's perioperative risk – Appendix 4

In addition to the PHQ, there are a range of other tools or sources for gathering information about the patient's medical condition. These may include existing records from a previous hospital visit, primary healthcare providers, surgeons or specialist physicians. See Additional Information to be obtained from the primary healthcare provider – Appendix 5.

When an incomplete PHQ is received, action should be taken to complete it by a clerk or if the medical history is complex, a nurse. This may, time permitting, be by mail, or telephone, and where appropriate, may involve the primary healthcare provider.

2.2.1 Transfer of Care from hospital Planning Questionnaire (TCPQ) triage

Screening for transfer of care from hospital for all patients is simultaneous with PHQ triage using the TCPQ (Appendix 3). The information provided on this questionnaire provides prompts for the screener to undertake further action depending on the information provided. This may include assessing the patient's level of frailty and level of community support, or prompt review for assistance from a member of the multidisciplinary team. This may include professional interpreters, pharmacists, physiotherapists, occupational therapists, speech pathologists, dietitians, podiatrists and social workers. The TCPQ may often be supplemented by a telephone call from a PPP/ PAC nurse.

The NSW Health Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Policy Directive[10] (PD2011_015) and Reference Manual[11] outlines requirements for NSW public hospitals.

To allow clinical decision making for patient safety and quality of care, there must at all times be readily accessible and updated documentation on each patient's aggregated health and social status.

Based on established local guidelines, the clinical screener reviews each completed questionnaire and the RFA to decide on the appropriate level of further review. Generally, the clinical screener may classify patients into one of the pathways and/or processes outlined in 2.3 (and see Model of care 1). Model of care 1 is long standing at one NSW teaching hospital and may be adapted as a template.

### 2.3 Pathways following PHQ triage

2.3.1 Limited to written education and telephone education and instructions

This can apply to minor surgery/procedure (e.g. DOS or EDO) for healthy patients with no systemic disease, or patients with well controlled simple chronic disease that does not require specific perioperative testing or management e.g. mild asthma.

The patient and carer should be provided with written education and instructions in plain language that is easy to understand. Instructions must be available in written form for culturally and linguistically diverse patients. The local multicultural or diversity health unit can assist with the development of translated written instructions. Where necessary, further instructions via telephone and the use of a professional interpreter should be used.

On the working day prior to surgery/procedure the patient (and/or carer) should receive telephone education with the nurse, including fasting, admission times and management of medications.

**Box 1: Phone call with the patient and/or carer on the working day prior**

Information discussed on the working day prior to the surgery/procedure should include:

- current health status
- smoking
- medication management
- CPAP machine
- results/x-ray
- fasting instructions for food and drink
- arrival time
- responsible adult available to accompany them at discharge.

On the day of surgery/procedure the patient will have a final assessment for fitness for surgery/procedure with their procedural anaesthetist[12].

2.3.2 Comprehensive telephone interview required

This can apply to patients described above, but also for patients where additional communication is required due to doubt regarding their functional capacity or social needs e.g. language, communication or other difficulties. A telephone interview to source more information from the patient, family, carer and/or primary healthcare provider may be required. A list of additional information that may be obtained from the primary healthcare provider and/or specialists is available at Appendix 5.

When the clinical screener is satisfied that no further review is required the patient and carer are provided with written and telephone education and instructions and review with their procedural anaesthetist as in 2.3.1.

2.3.3 PAC attendance required in person or via Telehealth

2.3.3.1 A **general PAC** is usually conducted by a team of an anaesthetist, nurse, medical officer (surgery team) and clerk and is necessary where further face-to-face assessment and preparation is required for:

- medical and anaesthetic optimisation of the patient's procedural/surgical journey, and/or
- nursing and allied health optimisation of the patient's transfer of care from hospital.

A general PAC can apply to patients with any of the following:

- presenting problem requiring moderately invasive surgery
- co-existing medical problems
- a pre-existing pain condition

- risk factors for perioperative morbidity
- risk factors for frailty and cognitive decline
- past history or family history of problems with anaesthesia
- difficulty obtaining any of the above information due to social or language difficulties
- difficulty obtaining any of the above information from the primary healthcare provider
- difficulty determining fitness for transfer of care from hospital on TCPQ
- where the patient, carer or a member of the health care team (e.g. surgeon, procedural anaesthetist, primary healthcare provider) requests a PAC review.

2.3.3.2 A **multidisciplinary PAC** is required for sicker patients or patients having more complex surgery (see Model of care 1). As appropriate, the general PAC team should liaise with other clinical and health disciplines including:

- subspecialty surgeons and nurses
- other medical specialists e.g. cardiologists, respiratory physicians, endocrinologists, renal physicians, geriatricians and rehabilitation physicians.
- Allied health professionals including pharmacists, physiotherapists, occupational therapists, social workers.
- GP and primary healthcare provider
- professional interpreter services, multicultural or diversity health units or Aboriginal Controlled Community Health Services (ACCHS) or Aboriginal Medical Services (AMS).

When the PAC team determines that no further assessment is required, the patient and carer are provided with written and telephone education and instructions and review with their procedural anaesthetist as outlined in section 2.3.1.

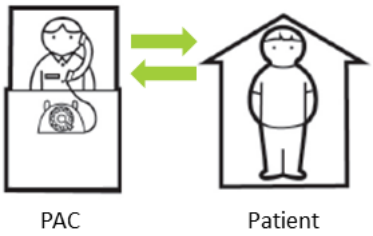
### 2.3.4 PAC and Telehealth

For patients living in rural, remote or isolated regions of NSW, it may be possible to arrange and conduct a PAC visit via Telehealth. The need and arrangements for Telehealth should be locally determined – guidelines on setting up and using this service are available on Telehealth page on the ACI website.

**Model of care 1: an example of a triage process at one NSW teaching hospital**

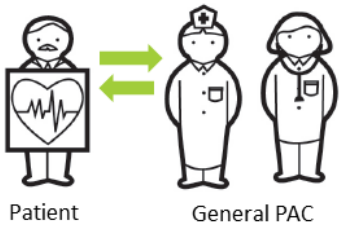
**Pathway One**
ASA I-II patients having minimally invasive surgery/procedure

- Patient health questionnaire review
- Phone interview if required
- No investigations or PAC visit required
- Written information and instructions provided to patient/carer
- Phone call on working day prior



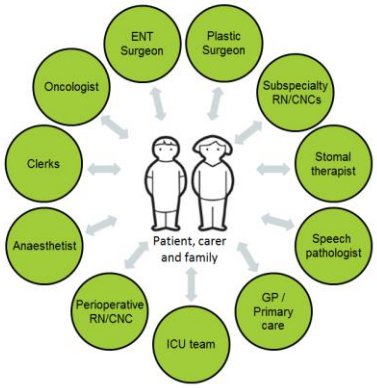

**Pathway Two**
ASA II-IV having moderately invasive surgery/procedure

- As for Pathway One, plus general pre admission clinic visit required
- Includes anaesthetist, surgeon and RN




**Pathway Three**
Patients having moderate and highly invasive surgery >2 hours and intended length of stay >48-72 hours. E.g. head and neck cancer patients, 4-8 hours surgery with planned ICU stay

- As for Pathway Two, plus multidisciplinary pre admission clinic visit required
- Includes anaesthetist, perioperative CNC, oncologist, ENT surgeon, plastic surgeon, CNCs for ENT, plastics, stomal care, speech therapist, social worker, ICU tour, physiotherapist




## 2.4 Paediatric patients

Many NSW public hospitals, both rural and metropolitan, provide paediatric services. While more complex, specialised work is referred to a tertiary paediatric centre, it is necessary for Local Health Districts (LHD) to support commonly occurring paediatric procedures. This is outlined in more detail in the NSW Health Guide to Role Delineation of Clinical Services[13] and the Surgery for Children in Metropolitan Sydney: Strategic Framework[14]. A list of further reading on NSW Health requirements for paediatric surgery is also available in the Reference list. Whilst the three tertiary paediatric hospitals will have specialised guidelines for children, the principles and tools outlined in this toolkit will also support high quality perioperative care for children.

**Box 2: Special considerations for pre procedure preparation for children**

- Children are a heterogenous group and age, weight, size, developmental stage and possible special needs e.g. diagnosed/associated behavioural problems are important considerations for patients, families and carers.
- Use a Paediatric PHQ – Appendix 2 – for assessment.
- Fasting times should be minimised to that prescribed in locally adapted guidelines.
- The key role of parents, guardians and carers should be supported with appropriate education.
- Phone communication one to two working days prior to the procedure/surgery may allay parents' and carers' anxiety and minimise cancellations on the day of surgery.

- timelines for the triage process
- who is responsible for reviewing and actioning results of investigations
- the standardised information to be given to patients and/or carers
- who is responsible for communicating the information to patients and/or carers.

All local staff, including visiting staff such as GP anaesthetists, should be made aware of these guidelines as part of their induction to the PAC and pre procedure processes.

**Within each service:**

2.5.1 Triage criteria

Triage criteria should be developed based on:

- the impact or complexity of the surgery/procedure
- each patient's medical and non-medical needs
- the local service and resources available for the Perioperative Service
- consultation with anaesthetists, surgeons and other relevant departments
- best practice guidelines and continuous local feedback based on agreed process indicators and health outcomes.

2.5.2 Guidelines for investigations and tests

Choosing Wisely has developed a range of resources to assist healthcare professionals and consumers in discussing and determining appropriate perioperative testing – detailed information and resources are available on the Choosing Wisely website[15]. Choosing Wisely Australia is following the work of this initiative in the United States and Canada – more information is available on the Choosing Wisely Australia website[16].

Each facility should develop preoperative testing guidelines for elective surgical patients. There is no evidence that young, healthy patients undergoing minor surgery should have routine preoperative testing[17]. The American Society of Anesthesiologists similarly recommends against baseline testing for low risk patients having a low risk procedure[18]. This applies to simple blood investigations including full blood count (FBC), electrolytes, urea and creatinine (EUC), calcium, magnesium, phosphate (CMP), coagulation studies, blood group and screen, ECG, chest x-ray (CXR). The American Heart Association (AHA) and American College of Cardiologists (ACC) advise against preoperative cardiac testing in patients with a low calculated risk of perioperative major adverse cardiac event (MACE)[19].

The National Institute for Clinical Excellence UK acknowledges that there is a paucity of high quality studies to allow definitive recommendations in the area of preoperative testing and that guidance should be used to develop and monitor local preoperative testing guidelines[17].

Preoperative tests provide a benefit where they:

- yield additional information that cannot be obtained from a patient history and physical examination
- help to assess the risk to the patient and inform discussions about the risks and benefits of surgery

- allow the patient's clinical management to be altered, if necessary, in order to reduce possible harm or increase the benefit of surgery
- help to predict postoperative complications
- establish a baseline measurement for later reference where potentially abnormal postoperative test results cannot be adequately interpreted in isolation.

### 2.5.3 Fasting guidelines

Fasting guidelines should be established. If there is no local protocol, general preoperative fasting advice is available on the ACI website.

### 2.5.4 Perioperative management of patient's medications

Guidelines for the perioperative management of patient's medications should be established, in particular for:

- patients on anti-platelet, anti-coagulant medications
- patients with Diabetes Mellitus on insulin and oral medications
- patients with a pre-existing pain condition.

### 2.5.5 Enhanced Recovery or Clinical Pathways

Enhanced recovery (ER) or clinical pathways (CP) should be established (See Element 5 or the Enhanced Recovery page on the ACI website).

## Element 3: Pre procedure preparation optimises and supports management of the patient's perioperative risks associated with their planned surgery/procedure and anaesthesia

Pre procedure preparation is concerned with:

- identifying the perioperative risks relevant for each patient
- supporting the communication and management of risks to maximal quality of recovery
- optimising each patient's preparation with regard to their:
    - medical condition for anaesthesia, surgery/procedure and recovery
    - nursing care, subspecialty and allied health care
    - transfer of care from hospital to their primary healthcare providers and other services as necessary
- ensuring that, where possible, the expectations of the patient, family, carer, the surgeon/proceduralist, procedural anaesthetist and primary healthcare provider are all met.

### 3.1 Further aspects of triage and examples of risk assessment tools

Further aspects of triage and examples of risk assessment tools, based on best practice, are explored in this section.

The AHA and ACC recommends dividing procedures into low-risk and other (medium or high-risk). Low-risk procedures are those with minimal fluid shift and without significant stress or impact. A low-risk procedure is one in which the combined surgical and patient characteristics predict a risk of MACE of death or myocardial infarction of <1%[19]. Low- risk examples include cataract surgery, endoscopy and day procedures.

An indicative list of surgery (minor to complex major) for both adults and children is also available in the Appendices of the NSW Health Guide to the Role Delineation of Clinical Services[13].

Functional status is a reliable predictor of perioperative and long-term adverse cardiac events. If functional status is not possible to assess for moderate to major stress surgery and if quantifying cardiac ischaemic threshold with pharmacologic stress testing will affect decision making, it may be reasonable to proceed to further cardiac testing[19] or cardiopulmonary exercise testing (CPX).

Precise calculation of perioperative risk may have implications for informed consent, or for perioperative planning, particularly with regard to postoperative destination (high dependency/close observation or intensive care unit placement)[19]. This assessment can ultimately impact on whether a facility has the capacity to undertake the procedure. Procedures with a risk of MACE of 1% or more are considered elevated risk. Where appropriate, patients should have an explicit mortality risk assessment documented. Particularly for high-risk patients, this should be discussed with the patient and carer, communicated to the surgical/procedural team and form part of the informed consent and shared decision making process[20]. A number of tools that can be used to assess perioperative mortality risk – examples include NSQIP Surgical Risk Calculator[21], P-POSSUM[22] and the Surgical Outcome Risk Tool[23].

However, not all perioperative adverse outcomes are cardiac. Specific areas of medical risk include patients with complex multisystem chronic disease. Appendix 4 lists a range of conditions or risk areas that should be considered as part of the patient's perioperative risk assessment.

### 3.2 The role of different health care professionals

3.2.1 The anaesthetist in the PPP/PAC

- Provides the general medical assessment identifying complex chronic multisystem disease and their diagnostic and management status.
- Orders relevant testing for the planned surgery/procedure (where this has not been done).
- Discusses and decides on more invasive perioperative testing with the patient and family/carer.
- Reviews test results and consultations from patients seen previously in PACs. Makes the appropriate management changes as a result of this testing. Informs the surgeon/proceduralist of unexpected finding e.g. a lesion on a CXR or a cardiologist recommending a delay in surgery for further investigations or management.
- Assesses the medical and anaesthetic risk and identifies the options for risk optimisation and for anaesthesia and the patient's perioperative care plan.
- Identifies postoperative pain management plan and flags any follow up/cessation plan for those who are opioid tolerant.
- Makes changes to the patient's management as required to optimise their medical condition or preparation for anaesthesia and surgery/procedure e.g. iron infusion, ceasing anti-inflammatory agents.
- Communicates information clearly to the patient and carer in a manner that supports shared decision making.
- Discusses with the patient the likely anaesthetic plan and any common alternatives to this. Answers any questions related to the patient's concerns about anaesthesia.
- Provides advice to the patient regarding their general health e.g. smoking cessation, reducing alcohol intake, weight reduction, nutrition, exercise, managing poor blood glucose control.
- Explains the processes related to the patient's admission and for DO ensures that the patient understands and can comply with the requirements of post-anaesthesia care e.g. has a responsible adult to take them home and stay on the first postoperative night[24].
- Seeks further information and where necessary makes referral to other specialists e.g. cardiologist, respiratory physician, endocrinologist, renal physician, haematologist, geriatrician, rehabilitation specialist in consultation with the GP, surgeon and procedural anaesthetist. Subsequently, where appropriate, this may also require referral back to the surgeon with advice on the patient's perioperative risk. Choosing Wisely has developed a range of resources to assist healthcare professionals and consumers in discussing and determining appropriate perioperative testing and treatment options[15].
- Communicates through written consultation, in the electronic medical record or directly with the procedural anaesthetist, surgeon and surgical team as appropriate.
- Documents the consultation in the patient's medical record. An example – Pre Admission Medical Anaesthetic Assessment Form is at Appendix 6 or on the Perioperative Toolkit page on the ACI website.

3.2.2 The primary healthcare provider e.g. GP, ACCHS, AMS or nurse practitioner

- Provides a patient health summary.
- Communicates with the PAC regarding the patient's health status and provides the results of relevant recent investigations and assessments (in particular cardiology assessments and investigations). A list of additional information that may be supplied by the primary healthcare provider is at Appendix 5 or available on the Perioperative Toolkit page on the ACI website.
- Where appropriate, assists patients with completing their PHQ.
- Plays a crucial role in supporting initial assessment and communicating with patients, especially those in rural areas or those requiring extra assistance.
- Plays a crucial collaborative role in optimising high-risk patients with complex chronic disease and prehabilitation for moderate to major stress surgery/procedure.
- Plays a crucial collaborative role in shared decision making and informed consent for high-risk medical – anaesthetic patients having high-risk surgery.
- Advises and refers patients to services that may be required postoperatively.
- In patients whose surgery may involve significant blood loss, assesses the iron status of the patient and where required and possible, administers intravenous iron injections.
- Follows up any new or worsening test results or new clinical findings in the PAC that will not be managed as part of the patient's surgery/procedure e.g. significantly elevated blood glucose level (BGL) or morbid obesity not requiring acute management or an asymptomatic ejection systolic murmur or early cognitive decline. (See also Element 7 Integration with primary care)

3.2.3 The PAC nurse or clinical nurse consultant (CNC)

- Reviews sources of information – e.g. PHQ, TCPQ, advice from the anaesthetist or GP – to ensure that referrals are made to subspecialty nurses and allied health clinicians.
- Coordinates PAC and attendance of the appropriate members of the multidisciplinary team.
- Collects baseline physiological data – e.g. weight, height, vital signs, finger prick BGL – and coordinates recent preoperative investigations/results, including necessary risk assessments.
- Liaises with appropriate stakeholders regarding patients with particular needs e.g. homeless patients, primary caregivers, people with disabilities, people from Aboriginal and Culturally and Linguistically Diverse backgrounds.
- Communicates information and preoperative instructions to patients and carers, including hospital information such as parking, arrival time, fasting requirements, management of medications, contact person, length of stay and general transfer of care information. Examples of a Perioperative Patient Information Booklet (Appendix 7) and Patient Information Checklist (Appendix 8) are on the Perioperative Toolkit page on the ACI website.
- Facilitates planning for and case manages the transfer of care from hospital by as needed referral to allied health, subspecialty surgical and other services such as the ACCHS /AMS.
- Communicates information to surgical/procedural and anaesthetic teams as required.

### 3.3 The expectations of patients, procedural anaesthetist, surgeon and proceduralist

3.3.1 Patient expectations

- Patients, their families and carers are an integral part of the health care team and are essential to ensuring a safe surgical/procedural journey.
- The patient and carer should be provided with information in a manner and format in which they understand on how their surgery/procedure is allocated and scheduled.
- The patient and carer must be provided with full information about their surgery/procedure, anaesthesia and recovery and their transfer of care from hospital to facilitate shared decision making and informed consent. NSW Health requirements for consent are outlined in the Consent to Medical Treatment – Patient Information Policy Directive[25] (PD2004_406), supplemented by the Clinical Procedure Safety Policy Directive[26] (PD2014_036).
- The patient, family and carer should understand:
    - admission details
    - fasting time
    - how to manage medications
    - how to manage equipment e.g. continuous positive airway pressure (CPAP) machine, personal subcutaneous insulin pump
    - expected length of hospital stay
    - transfer of care from hospital
    - anticipated time off work
    - anticipated progress of recovery at home and/or in primary care
    - pain management
    - contact details of hospital staff, in case further advice or other care is required
    - their rights and responsibilities.
- Where appropriate, the patient's concerns and expectations should be communicated to other members of the perioperative health care team.

3.3.2 Procedural anaesthetist, surgeon and proceduralist expectations

- The patient's medical condition has been optimised and perioperative risks management supported and communicated.
- The patient's medical history and results of investigations/consultations have been reviewed and there are no testing abnormalities or consultations results that require further acute management.
- The patient and carer are fully informed and consent for treatment has been documented.
- The patient understands and has followed PPP instructions.
- There is an appropriate postoperative pain management plan and/or advice regarding weaning and ceasing.
- There is an appropriate quality of recovery management plan agreed with the multidisciplinary team including the patient, family, carer and primary healthcare providers.

## Element 4: The multidisciplinary team collects, analyses, integrates and communicates information to optimise patient centred care

The Perioperative Service is comprised of a frontline multidisciplinary team of anaesthetists, nurses, surgical team medical officers, allied health clinicians and clerks who are responsible for liaising and facilitating the work of key stakeholders responsible for the patient's surgical/procedural journey. The Director, Perioperative Service or medical clinical lead and nurse clinical lead steer the frontline multidisciplinary team. These leaders are responsible for developing the service framework, its process indicators and health outcome measures for continuous quality improvement.

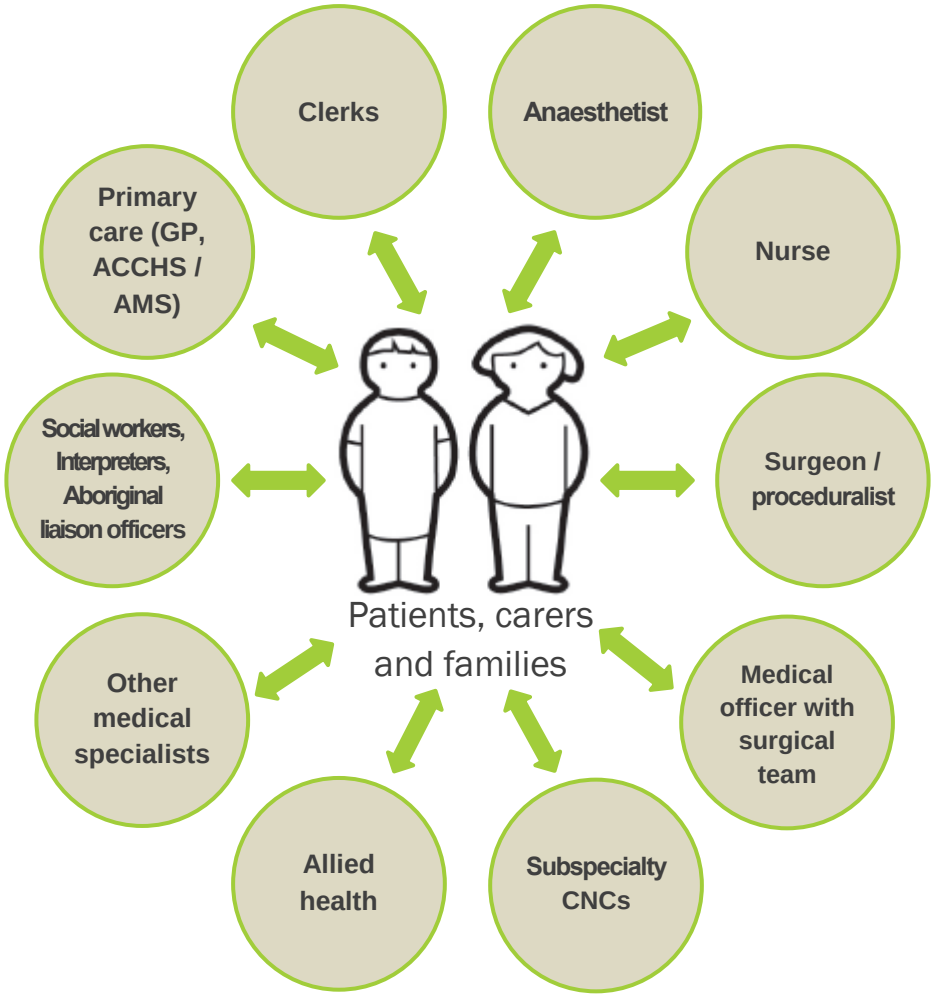
The members of the broader multidisciplinary team, the hospital and the district/network, should expect that the structures and processes of the frontline Perioperative Service are in place and working to facilitate their roles and responsibilities to patients, family and carers. The broader multidisciplinary team – e.g. senior surgeons/proceduralists, GPs and primary healthcare providers, specialist physicians – are consulted as appropriate, for all patients having more major surgery and/or significant chronic medical conditions, especially in the case of variance to planned care or an adverse event. All team members contribute to an optimal perioperative journey (Diagram 5).

At stages of the patient's perioperative journey, different team members more closely provide patient centred care.

- Before and after hospital admission it is the primary healthcare providers.
- During the most critical phase of care – intraoperative – it is the senior surgeon, the procedural anaesthetist and the OT nursing team.
- Preoperatively, it is the anaesthetist, the medical officer with the surgical team and the nurse with the clerk who spend most time with the patient, family and/or carer.
- Postoperatively the patient is primarily cared for by the medical officer of the surgical team and the ward nursing team.
- During all phases of care members of the perioperative team, including the broader multidisciplinary team, can be called upon to contribute their expertise to patient centred care.

Some roles may be delegated across professional groups depending on the resources available and on the size, type and location of the facility. To allow clinical decision making for patient safety and quality of care, there must at all times be readily accessible and updated documentation on each patient's aggregated health and social status. At all stages all members of the multidisciplinary team are responsible for checking that the patient information shows consistency e.g. the RFA, the consent form, correct site surgery, the ward notes, medications.

**Diagram 5: The perioperative multidisciplinary team**



## Element 5: Each patient's individual journey should follow a planned standardised perioperative pathway

### 5.1 The Standardised Perioperative Pathway

The Standardised Perioperative Pathway (SPP) is the first new tool of the Toolkit. It develops the pre procedure systems, structures and processes towards integrated perioperative care. The SPP is a communication tool for the multidisciplinary team that establishes from the outset – at PPP – what is anticipated as the patient's most likely perioperative journey to best possible functional recovery. The SPP enables variance to anticipated planned care to be marked for timely clinical attention The SPP takes into account a patient's medical status and perioperative risk as well as the impact of the patient's surgery/procedure – as outlined in the patient's ER or CP.

The SPP comprises the following features.

- Each patient's perioperative journey should comprise a series of anticipated common steps agreed upon by the multidisciplinary team during PPP.
- The SPP should be discussed and agreed with the patient.
- The SPP should be placed in the patient's medical records before the clinical notes for easy viewing and reporting.
- Where possible, an ER or CP should be attached to the SPP.
- A risk assessment based on the ASA Score[27] is documented.
- The pre, intra and postoperative risk management plan should be documented.
- Anticipated process indicators should be documented:
    - length of stay and level of ward care for patients post surgery/procedure
    - clinical handover from hospital to primary care
    - patient requirements for transfer of care from hospital.
- Variance to anticipated process indicators and health outcomes, including Rapid Response Team (RRT) calls, should be flagged and marked for attention to the clinical leads – medical (Director, Perioperative Service – Anaesthetist) and nursing (Perioperative Nurse Manager) – within 24 hours of the unanticipated event for continuous quality improvement.
- Ideally, this information, including variance, will be recorded on the tool by the medical officer of the surgical team or ward nursing team as part of the patient's standard care.
- Where variance has occurred, a revised SPP for that patient is required.
- The following should be communicated to the patient's primary healthcare provider:
    - the Anaesthetist (medical) consultation for risk score ASA IV and V patients
    - the event of an unanticipated ICU admission and/or other significant morbidity/mortality.

### 5.2 Enhanced Recovery and Clinical Pathways

Procedure specific ER or CPs are bundled care tools designed to improve the coordination and continuity of clinical care, particularly where different specialties and disciplines are involved.

Pathways are commonly seen as algorithms as they offer a series of sequential steps, or a flow chart of decisions to be made[28]. The use of structured care pathways are increasingly supported for a range of elective procedures – for example, the ACI Musculoskeletal Network's Evidence review on the pre, peri and postoperative care for patients undergoing a total hip or knee replacement indicated that the use of structured care pathways can reduce length of stay and show non-significant improvement in clinical outcomes[29]. An ER or CP will be determined by the surgery/procedure (i.e. specialty area) and should be adapted locally to meet the needs of the health district/hospital. Examples of LHD Enhanced Recovery pathways are on the Perioperative Toolkit page on the ACI website.

### 5.3 The Standardised Perioperative Pathway plus the Enhanced Recovery and/or Clinical Pathways

Where possible, information relevant to the patient's surgery/procedure should be recorded in the same format and location for each patient. This will not only streamline processes and ensure patient needs are aligned with resources, but will ensure there is one agreed location or a 'one stop shop' where members of the multidisciplinary team can find information on the patient's planned perioperative journey and/or variance. Ideally, this should be in the patient's electronic medical record.

This SPP plus the ER/CP:

- act as a prompt for the key steps in the perioperative process
- ensure that the management of the patient's perioperative journey continues until their transfer of care from hospital
- guide the medical officers of the surgical team and the ward nursing team (led by the Nurse Unit Manager) in coordinating and monitoring bundled care that is most often routine but may also require input from the senior surgeon/proceduralist and/or other medical specialists.

The SPP is a real time continuous quality improvement tool that is designed to capture health outcomes that patients, family, carers and clinicians value. Outcomes and process indicators are explored in more detail in the Element 6. The Standardised Perioperative Pathway tool is at Appendix 9 and is on the Perioperative Toolkit page on the ACI website.

In the example Model of care 2 on the next page, the SPP tool has been completed based on two patients on a total knee replacement Enhanced Management of Orthopaedic Surgery pathway.

The SPP tool has been used to document aspects of Sam and Sandy's perioperative journeys, including variance to intended outcome. At the outset, Sam (green/bold) is healthy ASA1. Sandy (blue/not bold and italics) ASA 3-4 has more complex chronic multi-system disease that has resulted in definite functional limitation and sometimes has been a threat to life. Unanticipated, Sam has variance requiring unplanned HDU (also known as COU) admission. Documentation and timely notification to the clinical leads – medical and nursing – are required plus notification to the patient's GP. A revised SPP is required for Sam and possibly, although not necessarily, revisions to the enhanced management pathway as well.

**Model of care 2: the Standardised Perioperative Pathway using a total knee replacement pathway at one hospital**

| *NSW public hospital* |
|---|

| New ■ | Revised ☐ | **Date:** DD/MM/YY |
|---|---|---|

| Surname: | MRN: |
|---|---|
| Given Name(s): | Male ☐ Female ☐ |
| D.O.B: | M.O: |
| Address: | |
| Location/ward: | |

| Form completed by: | **Dr J Bloggs** | | |
|---|---|---|---|
| Date: | **DD/MM/YY** | | |
| Planned Procedure: | **Total knee replacement** | | |
| Emergency/Elective: | **Elective** | | |
| Planned Care Pathway: | **Enhanced Management – Total Knee Replacement** | | |
| Expected length of stay: | X days / *Y days* | **Variance:** | Sam > X+3 days |
| Pathway discussed and agreed with the patient: | Yes ■ No ☐ | Notes: | |

| **Risk assessment – (For ASA IV and V please fax Anaesthetist consultation to GP):** | |
|---|---|
| Patient's ASA Score: | Sam – I *Sandy – III-IV* |

| **Perioperative risk management plan includes:** | | **Variance:** |
|---|---|---|
| Pre | As outlined in the pathway / *As outlined in pathway* | |
| Intra | As outlined in the pathway / *As outlined in pathway* | |
| Post | As outlined in the pathway / *As outlined in pathway* | |

| **Anticipated level of care for patients post procedure:** | | | | | **Variance:** |
|---|---|---|---|---|---|
| Day Surgery ☐ | EDO ward ☐ | Ward ■ | HDU ■ | ICU ☐ | Sam > HDU |

| **Clinical handover from hospital to primary care:** | | | **Variance:** |
|---|---|---|---|
| General Practitioner ■ | Community Nursing ■ | Family/Carer ■ | |

| **Patient requirements for transfer to primary care:** | | | | | **Variance:** |
|---|---|---|---|---|---|
| Transfer of care summary ■ | Pain Relief / Wean & cease plan ■ | Nominated carer ■ | Medications e.g. Warfarin ■ | Other ☐ | |

| **For ALL variance to the pathway (including RRT calls), DOCUMENT the variance and NOTIFY the Director, Perioperative Service (Anaesthetist) and Nurse Manager. A REVISED PLAN IS REQUIRED.** | | |
|---|---|---|
| Notified to: | NM/Director Perioperative Service informed of Sam's admission to HDU instead of ward. *No variance for Sandy so no notification req.* | Date: DD/MM/YY |

| **INFORM GP in the event of an unplanned admission to ICU and/or significant morbidity/mortality:** | | |
|---|---|---|
| Notified to: | Sam's GP informed of her unplanned admission to HDU instead of ward. *No variance for Sandy so no notification required.* | Date: DD/MM/YY |

## Element 6: Measurement for quality improvement, benchmarking and reporting should be embedded in the perioperative process

The perioperative process aims to ensure that:

- the patient receives the correct surgery/procedure within an appropriate timeframe
- complications are minimised.

To know to what degree these aims are being achieved, it is essential that there is a common understanding of 'what success looks like' and should take into account the perspectives of:

- patients, families and carers
- clinicians and clinical teams
- the hospital and District/Network
- the Ministry of Health.

Data collection should be integrated into the process of care to avoid unnecessary and fragmented documentation. Data collection can be for different purposes. This will determine the measures, metrics, timing and frequency. For example:

- quality improvement – at individual and department level
- benchmarking – with other organisations
- performance reporting – to the district/network or Ministry of Health
- research
- funding.

To meet these requirements, there are three major stages:

1. agreeing on indicators and measures, using data definitions where applicable
2. data collection, storage, analysis and reporting
3. using the data for improvement.

### 6.1 Developing a measurement framework

As a minimum, a suggested measurement framework should include:

- process measures
- performance indicators
- health outcomes
- patient centred outcomes (see also Element 8).

### 6.2 Performance indicators

Performance indicators should be monitored monthly. Many relevant indicators are collected monthly and reported on the Surgical Services Taskforce Dashboard. The performance indicator

for pre admission triage processes is cancellations on the day of surgery. This should be regularly benchmarked and managed. Causes are divided into:

- patient related factors
- hospital related factors.

### 6.3 Process measures

Process measures should be monitored daily (see Element 5 SPP) and reported monthly to assist LHDs and hospitals in assessing their Perioperative Service against the:

- elements of the perioperative care pathway
- deviation from the standardised perioperative pathway
- structural elements to support the care pathway
- length of stay.

Some of these process measures can be captured and documented on the SPP. Model of Care 2 outlines an example of two patients and one patient's subsequent variance from the perioperative care pathway. A self assessment tool is also available on the Perioperative Toolkit page on the ACI website.

### 6.4 Health outcomes

There are a range of health outcomes that may be collected and reviewed as part of process of continuous quality improvement. A suggested minimum set is outlined in the table below.

| Outcome | Measure | Metric |
|---|---|---|
| Survival | 30 day mortality<br>90 day mortality | |
| Recovery | Complications | • % Rapid Response Team calls within 24 hrs post-operative<br>• % Unplanned admission overnight<br>• % Unplanned admission to higher level care<br>• % Unplanned return to OT<br>• % Infection rate requiring further antibiotics (variance from ER or CP) |
| | Adequacy of post-operative pain management | • Presence of an opioid medication discharge wean and cease plan |
| | Unplanned readmission to hospital at 30 days, 90 days | |
| | Unanticipated residential aged care facility or nursing home admission with 6 months and 1 year post surgery | |

In selecting perioperative process measures, performance indicators and health outcome measures, these should be aligned where appropriate with the ACI's Operating Theatre Efficiency Guidelines (2014). The guidelines outline a minimum set of metrics that should be reviewed in monitoring and measuring OT performance[30].

### 6.5 Data collection, storage, analysis and reporting

There should be a systematic approach to collecting perioperative data.

- Where possible make use of existing data which can be extracted electronically, avoiding manual collection.
- Data collection is time consuming and must therefore be worthwhile. If the data is not being analysed and reported, it is time wasted.
- International leaders in this field such as the International Consortium on Health Outcomes Measurement (more information on the ICHOM website at www.ichom.org) recommend minimum data sets[31].
- Data definitions must be precise to allow accurate analysis and benchmarking.

Data management and reporting schedules should be determined by the group responsible for the governance of perioperative services. Accountability for the quality and outcomes of the perioperative system will therefore rest with this group as well.

Using the data for Quality Improvement

Regular reports should ideally be provided monthly, and at least quarterly to clinicians and managers. Where performance or outcomes are unsatisfactory, or trends are concerning, a quality improvement process should be initiated. For example, a Plan, Do, Study, Act (PDSA) cycle can be used to carry out small tests of change to address individual, team or organisational issues.

### 6.6 National Surgical Quality Improvement Program data and analysis

The American College of Surgeons National Surgical Quality Improvement Program (ACS NSQIP)[32] was developed to assist hospitals in measuring the quality of their surgical programs to improve surgical outcomes. The program uses hospital level data to analyse patient outcomes, in particular preventable complications. Clinicians and managers use the NSQIP analysis to inform local quality improvement.

The ACI Surgical Services Taskforce is supporting a pilot program in NSW. More information is available on the NSQIP page on the ACI website.

## Element 7: Integration with primary care optimises the patient's perioperative wellbeing

Beyond a hospital admission, it is the primary healthcare provider(s) who provide patient centred care. Primary care providers have a key role in the patient's perioperative journey. The relationship between a patient, family and carer and their primary healthcare provider (e.g. GP or AMS) often encompasses many years. Perioperative teams should take advantage of the primary healthcare provider's knowledge of the patient's physical, psychological, social and spiritual context.

### 7.1 Contribution of primary care to the Perioperative Service

The role of the patient's primary care provider in their surgical/procedural journey is multifaceted.

- Supports the patient, their families and carers in making decisions regarding surgery/procedures.
- Provides advice to the Perioperative Service on the patient's condition – medical, cognitive, emotional, social, functional. A list of additional information that may be provided by the primary healthcare provider is at Appendix 5.
- Provides advice to the Perioperative Service on the expectations of the patient, family, carer and other clinical specialists.
- Collaborates with the Perioperative Service for the diagnosis and optimisation of medical comorbidities or risk factors, prehabilitation and postoperative care where appropriate for:
    - patients with chronic complex multisystem disease
    - elderly patients
    - frail patients
    - patients with, or at risk of, cognitive decline
    - patients with metabolic syndrome
    - supporting the patient to modify their lifestyle e.g. smoking cessation, weight loss, exercise
    - patients with chronic pain and/or opioid tolerance
    - patients with obstructive sleep apnoea
    - perioperative Diabetes Mellitus management
    - perioperative Blood Management, in particular assessment of the patient's iron status and to organise iron replacement
    - patients on anti-platelet or anticoagulant medications that require cessation, substitution or re-commencement perioperatively
    - patients undergoing cancer treatment.
- Provides investigations and test results to the perioperative team in a timely fashion. This should be facilitated via a single point of contact within the Perioperative Service for the delivery (electronic, hard copy or fax) of reports for appropriate distribution.
- Supports transfer of care home, recovery and preventing readmission in consultation with the surgeon, community nurses and allied health professionals.

- Advises and refers patients to services that may be required postoperatively.
- Advises the Perioperative Service of adverse health outcomes related to the perioperative episode of care and other health outcomes as appropriate. This process should be facilitated via a single point of contact within the Perioperative Service.

### 7.2 Contribution of the Perioperative Service to primary care

Provision of accurate and timely information to the patient's primary care provider is an essential element of perioperative care. One of the key features of the SPP is to ensure that pertinent information relating to the patient's perioperative journey is shared with the primary healthcare provider. See Element 5.

As outlined in the Care Coordination Reference Manual, every GP, AMS or community nurse should receive a written transfer of care referral within 48 hours of the transfer[11]. Information should include:

- a summary of the patient's clinical episode of care
- a list of medications on discharge with information about:
    - changes to medications
    - follow up management of medications including a written pain management plan, e.g. wean/cease/reduce/increase/check [drug] after [some time interval].
- advice regarding follow-up arrangements, including:
    - those which have already been made
    - those which will be needed in future
    - details of community services involved or residential care arrangements
    - the need for additional services, or where services need to be reactivated, for example home care, residential care, mental health services, or drug and alcohol services.

Particularly for high-risk patients, if the patient has an unplanned admission to ICU, or medication prescriptions have changed perioperatively, upon their transfer of care, this information should be communicated directly via telephone to enable primary healthcare providers to deliver ongoing care for their patient.

### 7.3 Continuous quality improvement

As outlined in Element 5, it is considered best practice that the primary healthcare provider is notified by the hospital's Perioperative Service of a significant variance to the patient's anticipated perioperative journey. Ideally, the primary care practice will also notify the hospital's Perioperative Service of a patient mortality at 1, 3, 6 and 12 months and of significant variance or morbidity e.g. long term opioid requirements for pain, transfer from home to a residential aged care facility/nursing home for impaired quality of recovery – physical, cognitive, emotional or social.

#### Model of care 3: Health Pathways

A growing number of health services across NSW are partnering with their primary care organisations and local GPs to develop agreed clinical pathways across primary, community and acute care. These pathways describe the role of each of the providers for particular conditions or

situations. Through processes such as HealthPathways (originally developed by the Canterbury District Health Board)[33], there is great potential for broadening current inpatient clinical pathways into perioperative pathways. These pathways delineate the responsibilities of the patient, their primary healthcare provider, the surgeon, anaesthetist and other members of the perioperative team in the perioperative period. Central to this is improved communication between members of the patient's multidisciplinary team, reducing gaps in information, duplication of tests and improving the safety of transfer of care. HealthPathways is currently implemented or being implemented across a number of LHDs.

## Element 8: Partnering with patients, families and carers optimises shared decision making for the whole perioperative journey

The patient, family and carer are active members of the perioperative healthcare team. The Anaesthesia Perioperative Care Network has developed a booklet of stories from patients or their carers who have undergone anaesthesia and surgery. The patient stories contain prompts that may be useful for discussion in team meetings and are available under the 'Patient and carer project resources' heading of the Anaesthesia Perioperative Care Network resources page on the ACI website.

### 8.1 Shared decision making

*Providing care using a patient based care model ensures that care is respectful of and responsive to individual patient preferences, needs, and values. The model focuses on the relationships clinicians build with patients, family and carers as partners in health care delivery.*

*There is growing recognition that the safety and quality of care can be enhanced by engaging with patients, family and carers to improve health outcomes, the patient and staff experience, as well as safety and performance indicators[34].*

Partnering with Patients. Clinical Excellence Commission (CEC)

#### 8.1.1 Health literacy and decision support aids

In considering the most appropriate support aids for shared decision making, staff working in the Perioperative Service must be aware of the patient and/or carer's level of health literacy. This is particularly important when communicating perioperative risks to the patient and/or carer[35,36].

Where the patient and/or carer are from a culturally or linguistically diverse background, the NSW Health policy[37] on the use of professional interpreters must be followed to support communication with the patient, their families and carers. The Perioperative Service may also need to consider providing written instructions in a range of different languages, or in a multimodal format, e.g. including pictures and words. The hospital or district/network diversity health/health literacy committee should be engaged to provide advice.

More information to support clinicians, health services and consumers are available on the Health literacy page of the Australian Commission for Safety and Quality in Health Care website and the Partnering with patients: health literacy page of the CEC website.

### 8.2 A perioperative outcomes framework

Developing a framework for outcomes valued by patients, families and carers supports shared decision making for the perioperative journey.

The template outcomes framework (Diagram 6) has the following key features.

- Actively engages patients, carers, families and clinicians in considering:
    - their information needs pre, intra and post the surgery/procedure
    - their desired outcomes – what they want to get from having the surgery/procedure

- what they are not prepared to give up or risk by having their surgery/procedure and anaesthesia e.g. the ability to live independently at home.

- The left hand side of the diagram are the steps of the patient journey.
- The top row is the expectations of the multidisciplinary team, including the patient, family and carer.

### 8.3 Perioperative Patient Information Booklet

The Perioperative Patient Information Booklet – Appendix 6 – is a tool for patients, families and carers to use for.

- Recording information on their upcoming surgery/procedure, including:
  - admission time
  - fasting information
  - what to bring and/or not to bring to hospital
  - tests and medications
  - expected length of stay
  - expected time off work.
- Directions and information on where to go on the day of the surgery/procedure.
- Recording instructions discussed with a nurse in preparation for going home from hospital.

This tool can assist patients, families and carers in ensuring they have key information for their surgery/procedure recorded in one place. The surgeon or anaesthetist may also provide additional information or handouts relevant to the specific surgery/procedure.

An Outcomes Discussion Tool is also included in Appendix 7 for patients, families and carers to document the discussion regarding the perioperative outcomes framework – see 8.2.

A Patient Information Checklist – Appendix 8 – is another tool for clinicians and patients, families and carers for ensuring all the relevant information has been discussed.

Appendices 6, 7 and 8 are also available on the Perioperative Toolkit page on the ACI website.

### 8.4 Continuous quality improvement

Ideally, the patient, family and carer will also notify the hospital's Perioperative Service of a patient mortality at 1, 3, 6 and 12 months and of significant variance or morbidity e.g. long term opioid requirements for pain, transfer from home to a nursing home for impaired quality of recovery – physical, cognitive, emotional or social. This should be facilitated via a simple process and a single point of contact within the Perioperative Service. This will assist health services in continuous quality improvement through learning from their patients' experiences.

**Diagram 6: Outcomes framework for the patient journey**

| Patient journey | Patient perspective | GP perspective | Surgeon perspective | Anaesthetist perspective | Organisational perspective |
|---|---|---|---|---|---|
| **Decision to surgery – discussion re shared outcomes** | • Communication (risks, survival, opportunity to communicate ideal outcome to surgeon, perioperative pathway)<br>• Referral to appropriate specialist<br>• Access to professional interpreter if needed | | • Agreed plan with patient for surgery including intended outcomes, as well as risks and adverse outcomes | | |
| **Preoperative preparation – General (Surgery/procedure specific to be determined locally, by procedure)** | • Waiting time<br>• Explanation/ communication of planned perioperative pathway | | | • Patients requiring a PAC referred at an appropriate time before surgery<br>• All patients triaged<br>• Agreed plan for perioperative journey/pathway | • Waiting list categories<br>• Access to relevant services provided for patients/carers e.g. professional interpreter, Aboriginal liaison |
| **Intraoperative** | • Planned procedure is undertaken<br>• Anaesthesia or sedation is appropriate<br>• Procedure is safely and successfully | | • (Preventable) cancellations on day of surgery<br>• Clinical outcome achieved | • (Preventable) cancellations on day of surgery | • Cancellations on day or surgery<br>• Abandoned procedures<br>• Waiting list requirements<br>• Mortality |

| | | | | | |
|---|---|---|---|---|---|
| | completed | | | | |
| **Postoperative care in hospital** | • Pain management<br>• Mobility<br>• Length of stay<br>• Patient experience<br>• Agreed clinical outcome achieved<br>• Quality of recovery | • Unplanned admission to ICU<br>• Serious morbidity / mortality | • Complications e.g. unplanned admission to ICU, unplanned return to theatre, infection.<br>• Length of stay<br>• Deviation from ER pathway | • RRT calls<br>• Unplanned admission to ICU<br>• Deviation from planned perioperative pathway | • Mortality<br>• Length of stay |
| **Transfer of care from hospital to the community** | • Where to: Home / residential care etc<br>• Care information communicated to patients and carers<br>• Recovery: Time to return to work/lifestyle<br>• Access to other services e.g. professional interpreter | • Transfer of care communicated to GP<br>• Integrated pain management e.g. S8 scripts | • Readmission | • Readmission<br>• Integrated pain management | • Readmission<br>• Mortality<br>• Access to relevant services provided for patients/carers e.g. professional interpreter, Aboriginal liaison |
| **Care in the community** | • Access to advice where needed<br>• Follow up from hospital / with GP<br>• Quality of recovery<br>• Reactivate suspended home care services | | | | |

## Element 9: Effective clinical and corporate governance underpins the perioperative process

To address the economic challenges of safe access to elective surgery each NSW Health facility should have an integrated service in place for perioperative care and invest in strengthening the model of care. Clinical and corporate governance requires coordination and investment and is critical at the district/network, hospital/facility and Perioperative Service levels.

Importantly, the perioperative service should be supported and led by a clinical champion. Ideally the medical clinical leader or Director, Perioperative Service is an anaesthetist. An anaesthetist's continuing professional development and experience with surgeons and proceduralists informs this role:

- across all sub-specialties of surgery/procedure
- for all ages of patients and comorbid disease
- during the most critical time for patients in the perioperative period – in the OT/procedure room and post-acute care unit.

The medical clinical leader has a range of responsibilities.

- Collaborating closely with the nurse clinical leader each facilitating the other's leadership role.
- The coordination of perioperative multidisciplinary care.
- The collation, analysis and distribution of process indicators and health outcomes and initiation of quality improvement modifications, in consultation with the multidisciplinary team.
- The identification, management and communication of perioperative patient risk at pre admission and the perioperative case management of high-risk patients with the nurse clinical lead or delegate.
- The establishment of local guidelines including PAC triage process, perioperative risk management and prehabilitation, 'choosing wisely' when ordering investigations, tests or treatments, fasting times, medications management, integrated pain management, supporting the patient, family and carer's non-medical needs and with the surgical procedural team, ER CPs, perioperative patient information and criteria for transfer of care.

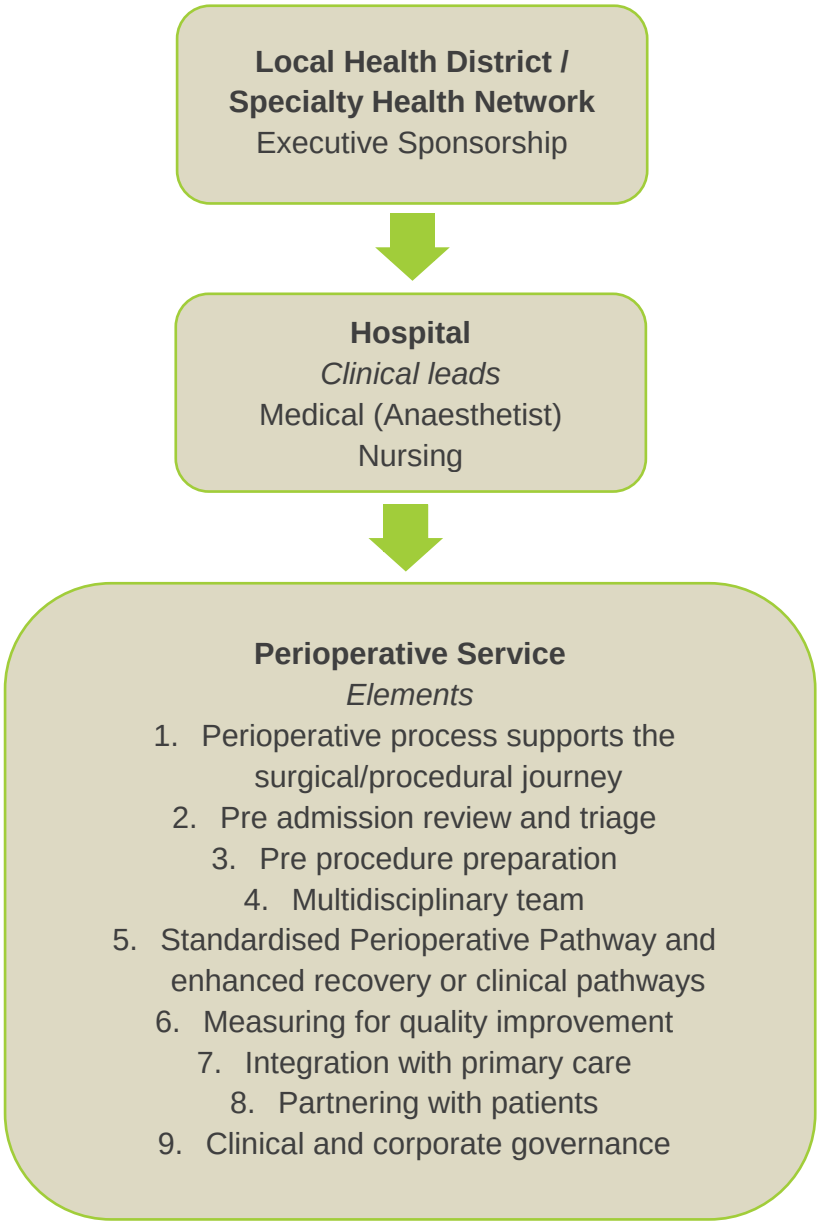
The nursing clinical leader has a range of responsibilities.

- Collaborating with the medical clinical leader, each facilitating the other's leadership role
- The coordination and oversight of the pre procedure preparation process, day of surgery admission, ward care, transfer of care from hospital to primary care with the involvement of the multidisciplinary team
- The collation, analysis and distribution of process indicators and health outcomes and initiation of quality improvement modifications, in consultation with the multidisciplinary team.

There must at all times be readily accessible and updated documentation on each patient's aggregated health and social status for the complete perioperative journey. Leadership is required for facilitating the latter at the patient level, in developing the electronic medical record and during the transition to a fully integrated electronic medical record, for the complete perioperative journey.

| Governance | | Activities and Responsibilities |
|---|---|---|
| Local Health District / Specialty Health Network |  | • Provides executive sponsorship for the continuing development of Perioperative Services.<br>• Ensures local structures, processes and tools meet the clinical and administrative needs of the patient during their perioperative journey.<br>• Directly engages and supports frontline clinical leaders in this task. |
| Hospital/facility |  | • Identifies a frontline clinician to be the Director, Perioperative Service and that, wherever possible, this medical clinical lead is an anaesthetist.<br>• Partners the medical clinical leader with a nurse clinical leader for the Perioperative Service.<br>• Supports the Director, Perioperative Service to engage local surgeons, anaesthetists, primary healthcare providers (GPs) and other key stakeholders in ensuring that perioperative structures, processes and outcome measures are well established to ensure patients are optimally prepared and managed for their surgery/procedure and perioperative journey.<br>• Supports the establishment of the frontline Perioperative Service made up of anaesthetists, nurses, clerks along with the broader multidisciplinary team members.<br>• Engages and supports the Perioperative Service, including the multidisciplinary team, in data collection and meeting agreed health outcomes and process indicators for individual patients and as a service team. |
| Perioperative Service |  | • The Director, Perioperative Service together with hospital/facility management, establishes the leadership team of senior anaesthetist/s and nurse/s to:<br>  ○ develop the service framework including local systems and processes, integration with primary care, partnering with patients<br>  ○ identify the frontline and broader multidisciplinary perioperative team members<br>  ○ liaise with and facilitate the work of key stakeholders also responsible for the surgical / procedural patient journey.<br>• Takes responsibility for supervising the collection, reviewing and managing of process indicators and health outcomes for individual patients and for the service. |

**Diagram 7: Clinical and corporate governance**



# Implementation and evaluation

### Implementation

To support local implementation of the Toolkit, the following components should be considered.

- Planning – develop an implementation plan which defines the overall project objectives, timelines and individuals responsible. High level timeframes should be developed at the start of the process and will further develop as the project evolves.
- Communication – develop a detailed communications plan for all stakeholders. It is a key element of a successful implementation and will facilitate engagement and ownership of the project.
- Finalise the case for change – create a clear definition of the present state, the potential change and the reasons for that change.
- Assessment – collect and analyse data about local current processes to identify and prioritise local issues for action.
- Operationalise – embed the Toolkit in local practice in a way that addresses the issues, gaps and priorities identified during the assessment.

More information is available on the Implementation Support section of the ACI website.

### Revision and evaluation

This Toolkit has been developed based on the best available knowledge and evidence at the time of writing. The Toolkit will be periodically reviewed for new information and clinicians and managers across Local Health Districts may provide feedback to the ACI at any time. Contact details for providing feedback to the ACI are available on page (i) of the Toolkit.

A formal evaluation may be undertaken on the Toolkit to review its effectiveness, as well as subsequent implementation processes across the Local Health Districts. This evaluation would inform any review of the Toolkit. This Toolkit is scheduled for review in three to five years.

More information on the ACI's evaluation process is available in Understanding Program Evaluation: an ACI Framework.

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**Further reading**

Below is a list of further reading or references which are provided in the Appendices.

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# Appendices

All tools referenced in this toolkit are available for download on Perioperative Toolkit page on the ACI website.

**Appendix 1: Patient Health Questionnaire – Adult**

**PATIENT HEALTH QUESTIONNAIRE**

| | |
|---|---|
| Surname | MRN |
| Given Name | Male ☐ Female ☐ |
| D.O.B: ____/ _____ /_____ | M.O. |
| Address | |
| | |
| Location/ward | |
| COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE | |
| Planned procedure: | |

Name / Known as:

**Patient to complete. If help is required ask your family, local doctor or phone:**

Are you (is the person) of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐

Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

*Please answer the questions by ticking the applicable box/es. Add any necessary details in the space provided. Where there is not enough space, please tick the box and attach an additional information sheet.*

1. Do you have any health problems other than your planned surgery? No ☐ Yes ☐
   If yes, please list: (For extra space add another sheet of paper). _____

2. Have you been in hospital for any health problems including previous surgery? No ☐ Yes ☐
   If yes, what and when were they? (Please list)

   Health problem/surgery | Hospital | Year

3. Have you seen any other specialist doctor/s in the last 5 years? If yes, please list: No ☐ Yes ☐

   Reason for seeing Dr | Dr's name | Dr's Phone Number | Last visit (date)

4. Do you use any regular medications? (e.g. pills, injections, puffers, implants, herbal, bush medicine and non-prescribed or recreational medications). If yes, please list: Attach list if more space needed. No ☐ Yes ☐

   Medication/dose: | When taken: | How often:

5. Do you have any allergies (especially to medicines, sticking plaster, iodine, food, latex). If yes, what are they and what reaction do you have? _____ No ☐ Yes ☐

6. Have you or any family member had a problem with an anaesthetic (e.g. a bad reaction). If yes, what happened? _____ No ☐ Yes ☐

7. Please indicate how far you can walk without stopping AND no chest pain or shortness of breath. Circle the one that best describes your condition. Note: A flight of stairs is considered approximately 6 steps.

| | | |
|---|---|---|
| More than 2 flights of stairs | 1 flight of stairs | Office Use Only – **PHQ TRIAGE INSTRUCTIONS** |
| 2 flights stairs | Half a flight of stairs | |
| | Around the house | |

**Appendix 1 – Patient Health Questionnaire – Adult – 1/2**

| | | |
|---|---|---|
| 8. Do you have any difficult opening your mouth or have limited neck movement? | No ☐ | Yes ☐ |
| 9. Have you had any recent anaesthetics? If yes when was the last one? | No ☐ | Yes ☐ |
| 10. Do you have any questions, worries or concerns about the anaesthetic that you would like to talk to us about? If yes, what are they? | No ☐ | Yes ☐ |

11. Do you have or have you ever had:

| | | | |
|---|---|---|---|
| High blood pressure | No ☐ | Yes ☐ | When: _____ |
| Heart attack, chest pain or 'angina' | No ☐ | Yes ☐ | When/How often: _____ |
| Any other heart condition e.g. heart valve, pacemaker | No ☐ | Yes ☐ | What type _____ |
| Lung problems needing hospital | No ☐ | Yes ☐ | What type: _____ |
| Troublesome shortness of breath | No ☐ | Yes ☐ | When do you get it: _____ |
| Chronic bronchitis | No ☐ | Yes ☐ | When: _____ |
| Asthma | No ☐ | Yes ☐ | How often: _____ |
| Should you be using a puffer (e.g. Ventolin)? | No ☐ | Yes ☐ | How often: _____ |
| Sleep apnoea | No ☐ | Yes ☐ | CPAP machine (Y/N): _____ |
| Other lung or breathing problems | No ☐ | Yes ☐ | What type: _____ |
| Reflux of acid or food – heartburn / hiatus hernia | No ☐ | Yes ☐ | How often: _____ |
| Diabetes | No ☐ | Yes ☐ | Insulin (Y/N): ___ Tablets: (Y/N) ____ |
| Epilepsy or fits | No ☐ | Yes ☐ | How often: _____ |
| Stroke | No ☐ | Yes ☐ | When: _____ |
| Blackouts or fainting | No ☐ | Yes ☐ | When: _____ |
| Past episodes of Delirium | No ☐ | Yes ☐ | Describe: _____ |
| Dementia | No ☐ | Yes ☐ | Describe: _____ |
| Intellectual disability | No ☐ | Yes ☐ | Describe: _____ |
| Chronic pain | No ☐ | Yes ☐ | Opioids (Y/N): _____ |
| Blood clots or a bleeding disorder | No ☐ | Yes ☐ | What type: _____ |
| Anaemia | No ☐ | Yes ☐ | When: _____ |
| Previous blood transfusion | No ☐ | Yes ☐ | When: _____ |
| Kidney condition | No ☐ | Yes ☐ | What type: _____ |
| Hepatitis or liver condition | No ☐ | Yes ☐ | What type: _____ |
| Is there a condition that runs in the family e.g. thalassemia, muscular dystrophy? | No ☐ | Yes ☐ | What condition: _____ |
| Do you have any other health issues not mentioned above e.g. poor teeth, rheumatoid arthritis, recent Prednisone? | No ☐ | Yes ☐ | List: _____ |
| An infectious disease (e.g. 'golden staph', HIV, TB)? | No ☐ | Yes ☐ | List: _____ |
| Are you pregnant? | No ☐ | Yes ☐ | |
| Do you smoke? | No ☐ | Yes ☐ | How much: _____ |
| Do you drink alcohol? | No ☐ | Yes ☐ | How much per week: _____ |

Height: ☐ Weight: ☐

Form completed by: Patient ☐ Carer/relative ☐ Other ☐ Specify:

Signature of person completing form: Date:

**Appendix 1 – Patient Health Questionnaire – Adult – 2/2**

## Appendix 2: Patient Health Questionnaire – Paediatric

### PATIENT HEALTH QUESTIONNAIRE

**Patient 's parent/guardian to complete. If help is required ask your family, local doctor or phone _____.**

| | |
|---|---|
| Surname | MRN |
| Given Name | Male ☐ Female ☐ |
| D.O.B: ____/ _____ / _____ | M.O. |
| Address | |
| | |
| Location/ward | |

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

| | |
|---|---|
| Patient Name / Known as: | |
| Who will bring the child to hospital? (Name): | |
| Relationship to child: | |
| Phone: | |
| Are they the legal guardian? No ☐ Yes ☐ | |

*Office use only*

| | |
|---|---|
| Age: | |
| Weight: | |
| Height: | |
| Planned procedure: | |

Are you (is the person) of Aboriginal or Torres Strait Islander origin? No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

*Please tick the applicable box/es and add any necessary details in the space provided. Where there is not enough space, please tick the box and attach the additional information sheet.*

1. Was your child born prematurely? No ☐ Yes ☐ How many weeks?
2. Does your child have any health problems other than your planned procedure/surgery? If yes, please list: (For extra space add another sheet of paper). No ☐ Yes ☐

3. Has your child been in hospital for any health problems including previous surgery? If yes, what and when were they? (Please list) No ☐ Yes ☐

| Health problem/surgery | Hospital | Year |
|---|---|---|
| | | |
| | | |

4. Does your child have any diagnosed disabilities or special needs? If yes, please list. No ☐ Yes ☐

5. Has your child seen any other specialist doctor/s? If yes, please list: No ☐ Yes ☐

| Reason for seeing Dr | Dr's name | Dr's Phone Number | Last visit (date) |
|---|---|---|---|
| | | | |
| | | | |

6. Does your child use any regular medications? (e.g. pills, injections, puffers, implants, herbal, bush medicine and non-prescribed medications). If yes, please list below. Attach list if more space req. No ☐ Yes ☐

| Medication/dose: | When taken: | How often: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Appendix 2 – Patient Health Questionnaire – Paediatric – 1/2

7. Does your child have any allergies (especially to medicines, sticking plaster, iodine, food, latex). No ☐ Yes ☐

If yes, what are they and what reaction do they have? _____

8. Has your child had previous anaesthetics? If yes, what for and when? _____ No ☐ Yes ☐

9. Are you aware of any problems your child has with general anaesthetics? No ☐ Yes ☐

If yes, please describe: _____

10. In your child's family, are you aware of any problems with general anaesthetics? No ☐ Yes ☐

If yes, please describe: _____

11. Do you or your child have any questions about the anaesthetic? If yes, what are they? No ☐ Yes ☐

12. Does your child have at present or have they ever had:

| | | If yes: |
|---|---|---|
| A recognised medical condition or syndrome? | No ☐ Yes ☐ | Condition/doctor: _____ |
| Heart problems | No ☐ Yes ☐ | Condition/doctor: _____ |
| Asthma | No ☐ Yes ☐ | How often: _____ |
| Should your child be using a puffer (e.g. Ventolin) | No ☐ Yes ☐ | How often: _____ |
| Other lung or breathing problems (e.g. snoring, stops breathing during sleep – sleep apnoea) | No ☐ Yes ☐ | What type: _____ |
| Reflux of acid or food – heartburn / hiatus hernia | No ☐ Yes ☐ | How often: _____ |
| Diabetes | No ☐ Yes ☐ | What type & treatment: _____ |
| Previous exposure to cortisone, similar steroids | No ☐ Yes ☐ | When & what type: _____ |
| Epilepsy or fits | No ☐ Yes ☐ | How often: _____ |
| Bleeding or bruising problems | No ☐ Yes ☐ | What type: _____ |
| Bleeding or bruising problems in a family member | No ☐ Yes ☐ | What type: _____ |
| Anaemia or previous blood transfusion | No ☐ Yes ☐ | When: _____ |
| Kidney condition | No ☐ Yes ☐ | What type: _____ |
| Hepatitis or liver condition | No ☐ Yes ☐ | What type: _____ |
| Is your child's immunisation up to date? | No ☐ Yes ☐ | What type: _____ |
| Has your child had exposure to in the last three weeks, or do they currently have measles, chicken pox, rheumatic fever, or any other infectious disease? | No ☐ Yes ☐ | What type: _____ |
| Is there a condition that runs in the family e.g. thalassemia, muscle dystrophy? | No ☐ Yes ☐ | What condition: _____ |

Form completed by: Parent ☐ Carer/relative/guardian ☐ Other ☐ Specify:

Signature of person completing form: Date:

**Appendix 2 – Patient Health Questionnaire – Paediatric – 2/2**

## Appendix 3: Transfer of Care from Hospital Planning Questionnaire

**TRANSFER OF CARE FROM HOSPITAL PLANNING QUESTIONNAIRE**

| | |
|---|---|
| Surname | MRN |
| Given Name | Male Female |
| D.O.B: ____/ _____ / _____ | M.O. |
| Address | |
| | |
| Location/ward | |
| COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE | |

Name / Known as:

Are you (is the person) of Aboriginal or Torres Strait Islander origin?

No ☐ Yes, Aboriginal ☐

Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

If Yes, refer to Aboriginal Liaison Service. ☐

*You are presently on the waiting list for surgery at _____. To assist with planning for your hospitalisation and transfer home, would you please complete these questions by ticking the appropriate box/es. If you require help, ask your family, carer or local doctor.*

| | Office Use Only |
|---|---|
| 1. Age _____ | |
| 2. Do you speak English at home? If no, which language do you speak: ☐ No ☐ Yes<br>_____ | Yes? Action: Book interpreter ☐ |
| 3. Do you need a professional interpreter? ☐ No ☐ Yes | |
| 3. Do you have problems with your memory? Has your doctor talked with you about cognitive impairment, dementia or previous delirium? ☐ No ☐ Yes | Yes? Action: For PAC ☐ |
| 4. What is your understanding of how long you will be in hospital?<br>Day only ☐ Overnight ☐ 1-2 days ☐<br>2-5 days ☐ Unsure ☐ More than 1 week ☐ | Is this correct? Y ☐ N ☐→ Action |
| 5. Have you made arrangements for someone to take you home from hospital? (A responsible adult must accompany Day Only patients home, and must stay with them at least for the first night after surgery). ☐ No ☐ Yes | No? Action: Contact patient ☐ |
| 6. Do you live:<br>Alone ☐<br>With family ☐<br>With carer ☐<br>Nursing home ☐<br>7. Where do you live:<br>House/unit ☐<br>Boarding house ☐<br>Hostel ☐<br>Other: _____ | Alone, boarding house, hostel? Action: Contact patient ☐ |
| 8. Do you care for another person on a regular basis? ☐ No ☐ Yes | Yes, then No? Action: Contact patient ☐ |
| 9. Have alternative arrangements been made to look after this person? ☐ No ☐ Yes | |
| 10. Do you normally need assistance to walk? ☐ No ☐ Yes | Yes?→ Look at procedure |
| 11. Do you use a walking aid such as a stick or frame? If yes, what type? ☐ No ☐ Yes<br>_____ | Yes?→ |
| 12. Do you have stairs at home? If yes, how many and are they indoors/outdoors: ☐ No ☐ Yes<br>_____ | Yes?→ Look at procedure |
| 13. Do you have difficulties with your sight? Please describe: ☐ No ☐ Yes<br>_____ | Yes?→ |
| 14. Do you have any difficulties with your hearing? Please describe: ☐ No ☐ Yes<br>_____ | Yes?→ Look at procedure |

**Appendix 3 – Transfer of Care from Hospital Planning Questionnaire – Adult – 1/2**

| | Office Use Only |
|---|---|
| 14. On discharge, do you think you will have any problems with: | |
| Bathing / showering No ☐ Yes ☐ | Qs 14 – 17: Yes to any of these? |
| Dressing No ☐ Yes ☐ | Action: |
| Toileting No ☐ Yes ☐ | Referral made: ☐ |
| Cooking No ☐ Yes ☐ | Date:_____ |
| Cleaning No ☐ Yes ☐ | Discharge planner ☐ |
| Shopping No ☐ Yes ☐ | Social worker ☐ |
| Business matters No ☐ Yes ☐ | Physiotherapist ☐ |
| Family matters No ☐ Yes ☐ | Occ. Therapist ☐ |
| Other: _____ Describe: | |
| 15. On discharge, do you think you will require help at home (that cannot be provided by your current support network)? No ☐ Yes ☐ | Document discharge plan ☐ |
| 16. What arrangements have been made for someone to care for you when you get home? | |
| | |
| | |
| 17. Do you currently use any of the following services? | |
| Community nurse ☐ Personal care assistance ☐ Meals on Wheels ☐ | |
| Home Help ☐ Aboriginal Specific Services ☐ Day care / therapy unit ☐ | |
| Other: ☐ Describe: _____ | |

**Please ask for assistance, as staff are available to assist you with any concerns.**

Thank you for completing this form.

The information you have provided will help in planning your transfer of care from hospital.

**HOSPITAL USE ONLY**

| | | | | | |
|---|---|---|---|---|---|
| Expected length of stay: | | Actions completed: | | Intervention required: | No ☐ Yes ☐ |
| Telephone intervention: | No ☐ Yes ☐ | Action: | | | |
| Screened by: (RN) | | Signature: | | Date: | |

Referrals to be made to:

| | | |
|---|---|---|
| Social work ☐ | CNC Discharge liaison ☐ | Physiotherapy ☐ |
| Stomal therapy ☐ | Occupational therapy ☐ | CA/PAC ☐ |
| Drug & Alcohol ☐ | Aboriginal Liaison ☐ | Interpreter ☐ |

Other: ☐ Describe: _____

| | | | |
|---|---|---|---|
| Requires Pre Admission Clinic | | | No ☐ Yes ☐ |
| Appointment made by (administrative staff): | | Signature: | Date: |
| Appointment date: | | | |

**Appendix 4: Conditions/considerations for Assessing a Patient's Perioperative Risk**

| Condition / Consideration | Further Reading and Reference Guidelines |
|---|---|
| Poor or indeterminable cardiorespiratory reserve or exercise tolerance | Fleisher LA, Fleischmann KE, Auerbach AD, et al. 2014 ACC/AHA Guideline on Perioperative Cardiovascular Evaluation and Management of Patients Undergoing Noncardiac Surgery: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol.* 2014;64(22):e77-e137. doi:10.1016/j.jacc.2014.07.944. Accessed at http://content.onlinejacc.org/article.aspx?articleid=1893784, March 2016. |
| Chronic Obstructive Pulmonary Disease / Emphysema or people on home $O_2$/CPAP/NIV/ventilation | Beasley, R., Chien, J., Douglas, J., Eastlake, L., Farah, C., King, G., Moore, R., Pilcher, J., Richards, M., Smith, S. and Walters, H. (2015), Thoracic Society of Australia and New Zealand oxygen guidelines for acute oxygen use in adults: 'Swimming between the flags'. Respirology, 20: 1182–1191. doi:10.1111/resp.12620 |
| High body mass index (BMI) | Queensland Health \| Statewide Anaesthesia and Perioperative Care Clinical Network Guideline – Anaesthesia: non-bariatric surgery in obese patients https://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-395.pdf |
| Obstructive sleep apnoea | STOPBang Questionnaire http://www.stopbang.ca/osa/screening.php |
| Older surgical patients | Optimal Perioperative Management of the Geriatric Patient: Best Practice Guideline from ACS NSQIP / American Geriatrics Society https://www.facs.org/~/media/files/quality%20programs/geriatric/acs%20nsqip%20geriatric%202016%20guidelines.ashx<br>The Association of Anaesthetists of Great Britain & Ireland. 2014. Safety Guideline – Perioperative Care of the Elderly. https://www.aagbi.org/sites/default/files/perioperative_care_of_the_elderly_2014.pdf |
| Patients who will require rehabilitation services or ongoing acute care | TBA (Advice currently being developed). |
| Frailty | Victorian Government / Health https://www2.health.vic.gov.au/hospitals-and- |

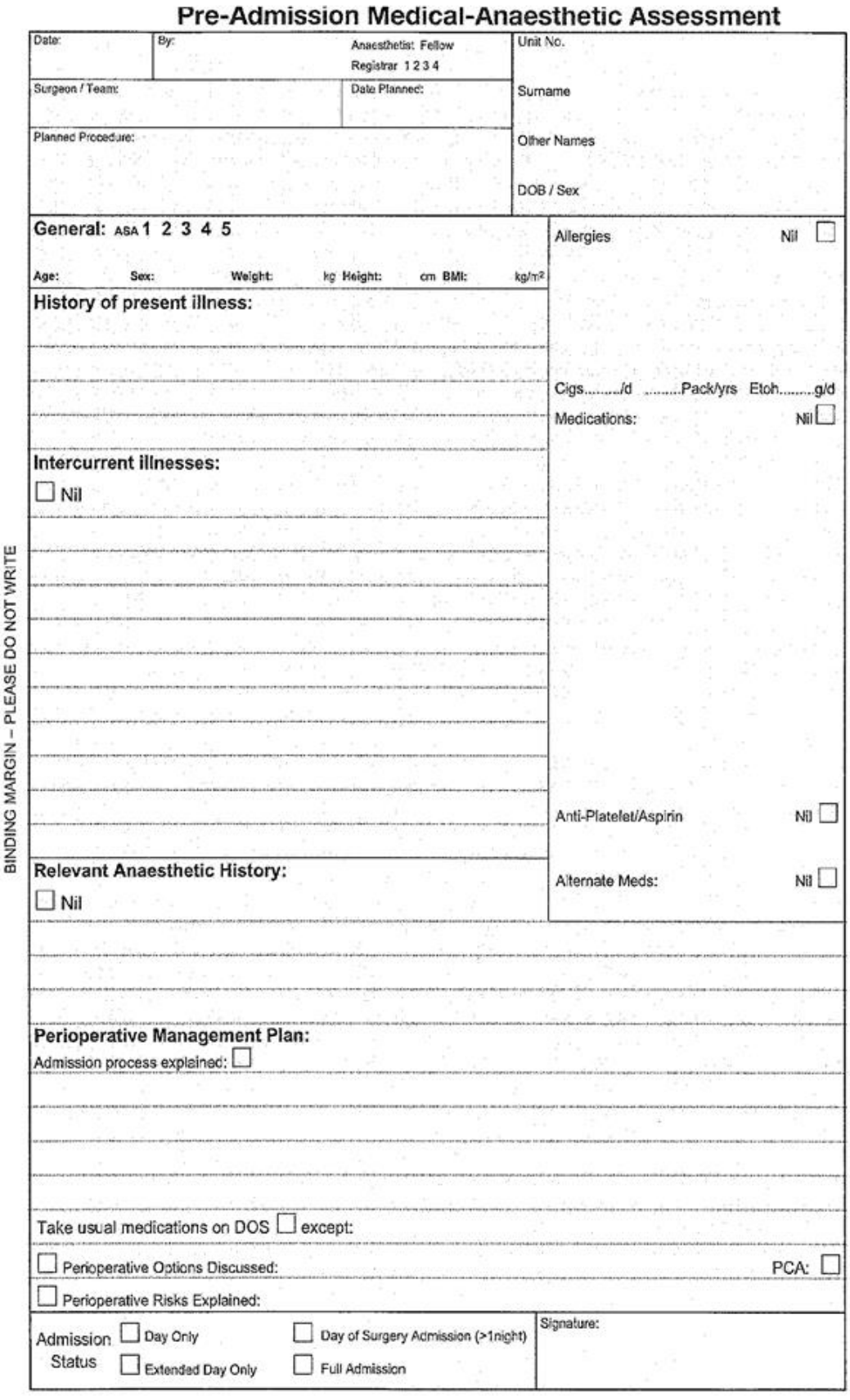
| | |
|---|---|
| | health-services/patient-care/older-people/frailty |
| Cognitive impairment<br>Dementia, early cognitive decline (at risk of post-operative cognitive dysfunction) or delirium (or past episodes of delirium) | Care of the Confused Hospitalised Older Person<br>http://www.aci.health.nsw.gov.au/chops<br>Australian Commission on Safety and Quality in Health Care \| Delirium Clinical Care Standard<br>https://www.safetyandquality.gov.au/our-work/clinical-care-standards/delirium-clinical-care-standard/ |
| Intellectual disability | Intellectual Disability Resources<br>https://www.aci.health.nsw.gov.au/networks/intellectual-disability/resources |
| Smoking reduction / cessation | Tobacco and Smoking – Tools for Health Professionals<br>http://www.health.nsw.gov.au/tobacco/Pages/tools-for-health-professionals.aspx |
| Alcohol Dependence | Drug and Alcohol Publications and Resources<br>http://www.health.nsw.gov.au/mentalhealth/Pages/pubs-index-da.aspx |
| Presence of chronic pain +-/- opioid tolerance (e.g. Opioid use > 40 mg oral ME per day) | NSW Therapeutic Advisory Group Inc<br>Preventing and managing problems with opioid prescribing for chronic non cancer pain<br>July 2016<br>http://www.ciap.health.nsw.gov.au/nswtag/reviews/practical-guidance.html |
| Risk of transition to chronic pain after surgery or a procedure | NPS Medicine Wise<br>https://www.nps.org.au/australian-prescriber/articles/postoperative-pain-management#acute-to-chronic-pain-transition |
| Low ferritin and anaemia | Patient Blood Management Guidelines: Module 2 Perioperative<br>https://www.blood.gov.au/pbm-module-2 |
| Poor blood glucose control | A Perioperative Diabetes and Hyperglycaemia Guideline is currently being developed by the Australian Diabetes Society and the Australian and New Zealand College of Anaesthetists and will be available on those websites upon its release. |
| Renal function | Guidance from the Renal Society |

**Appendix 5: Additional Information to be Obtained from the Primary healthcare provider**
Ideally, the following information should be obtained from the primary healthcare provider (GP, ACCHS/AMS) by the Perioperative Service:

| Data/Information from the Primary healthcare provider |
|---|
| Patient identifiers, including name, date of birth |
| Was the primary healthcare provider involved in completing the patient health questionnaire?<br>If yes, were the answers accurate? |
| A Health Summary |
| Other specialists currently caring for the patient and copies of the recent letter/s from the patient's specialists |
| Current medications |
| Recent test results e.g. chest x-rays, serum chemistry, HbA1c for Diabetes, haemoglobin/ferritin and Thyroid Function tests |
| Copies of investigations that have been done, especially the most recent Cardiac Echocardiogram, Stress Test/s, Coronary Angiogram |
| Past procedures, within a set timeframe (as requested by the Perioperative Service) |
| Details of any anaesthetic complications the patient may have had |
| Details of any allergy testing that might have been done |
| Control/stability of major chronic medical problems, e.g. Diabetes, hypertension, chronic pain |
| Details of cognitive impairment including past episodes of delirium |
| An assessment of the patient's general mobility and functional ability |
| Any non-medical needs of the patient, including caring for another person, the need for a professional interpreter, social worker, Aboriginal hospital liaison service etc |
| Name of the practitioner, practice and contact details |

The primary healthcare provider should be given one point of contact within the Perioperative Service for providing this information and to discuss any matters relating to the patient's planned perioperative journey.

## Appendix 6: Pre Admission Medical Anaesthetic Assessment Form



### Pre-Admission Medical-Anaesthetic Assessment

| Date: | By: | Anaesthetist: Fellow<br>Registrar 1 2 3 4 | Unit No. |
|---|---|---|---|
| Surgeon / Team: | | Date Planned: | Surname |
| Planned Procedure: | | | Other Names<br>DOB / Sex |

**General:** ASA 1 2 3 4 5

Age: Sex: Weight: kg Height: cm BMI: kg/m²

**History of present illness:**

**Intercurrent illnesses:**

☐ Nil

**Relevant Anaesthetic History:**

☐ Nil

Allergies Nil ☐

Cigs...../d .....Pack/yrs Etoh.....g/d

Medications: Nil ☐

Anti-Platelet/Aspirin Nil ☐

Alternate Meds: Nil ☐

**Perioperative Management Plan:**

Admission process explained: ☐

Take usual medications on DOS ☐ except:

☐ Perioperative Options Discussed: PCA: ☐

☐ Perioperative Risks Explained:

Admission Status ☐ Day Only ☐ Day of Surgery Admission (>1night) ☐ Extended Day Only ☐ Full Admission

Signature:

BINDING MARGIN – PLEASE DO NOT WRITE

# PRE-ADMISSION EXAMINATION & EVALUATION

## CARDIOVASCULAR

BP:..... HR:..... reg irreg

JVP:.....

Carotids:.....

HS:..... 1 2

.....

Ankle oedema:.....

Pulses:.....

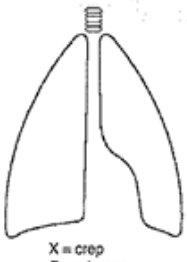
Exercise tolerance:..... Limited by:.....

ECG:.....

Thallium / Stress Test / Echo / Angiogram:.....

## RESPIRATORY

$SpO_2$:.....%



X = crep
O = wheeze

Breathlessness: Nil Moderate Exertion Mild Exertion At Rest

Examination:.....

CXR / CT:.....

Spirometry, Lung Function Tests:.....

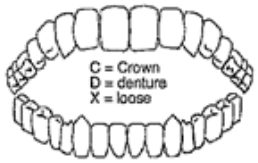
ABG's on..... $\%O_2$: pH..... $pO_2$..... $pCO_2$..... Bicarb..... BE..... Sat..... %

More:.....

## AIRWAY & TEETH

Mallampatti / Gatt Score

Class 1 Class 2 Class 3 Class4




Dentures Nil Upper: Full Partial Lower: Full Partial

Teeth:.....

Jaw opening:..... Atlanto-Axial Extension:.....

Neck Flexion:.....

More:.....

## NEUROLOGICAL

| | R | L |
|---|---|---|
| Power | | |
| UL | /5 | /5 |
| LL | /5 | /5 |
| Pupils | | |

Hearing:.....

Vision:.....

More:.....

## OTHER

.....

.....

.....

## BLOOD RESULTS

BIOCHEM: Na..... K..... Cl..... $TotCO_2$..... BSL..... Creat..... Ca..... LFT's.....

HAEM: Hb..... WCC..... Plats..... INR..... APTT..... Groups&Screen.....

OTHER:.....

Binding Margin – Please do no write

**Appendix 6 – Pre Admission Medical Anaesthetic Assessment Form – 2/2**

**Appendix 7: Perioperative Patient Information Booklet**

## Appendix 7 – Perioperative Patient Information Booklet – 1/3

### Patient Information Booklet and Checklist

Your guide to the Perioperative Service at _____ Hospital. The Perioperative Service is responsible for helping organise your care before, during and after your operation.

You have been given this guide because you are having an operation. You are probably asking 'what do I need to know' and 'what do I need to do'?

This booklet will help with:

- before coming to hospital
- during your hospital stay
- after you leave hospital

It also includes what to bring, what not to bring and where to go. You need to bring this booklet with you when you come to hospital. You may also be provided with detailed information by your surgeon or the anaesthetist.

If you have any questions, please call the Perioperative Service on (02) ____ ____.

Please tell the nurse when you speak with them if you have had:

- changes in how you are feeling
- recent flu or colds
- been to hospital in the past two weeks
- changes to the medicines you take
- injuries or scratches

### Preparing to come to hospital

| | Need to know | Write here |
|---|---|---|
| | Time to arrive at the Perioperative Unit | |
| | Time to stop eating | |
| | What you can drink and time to stop drinking | |
| | The medicines/tablets you should take on the day of your surgery with some water | |
| | If you have diabetes | |
| | To bring the results of blood tests and x-rays | |
| | How long you are likely to stay in hospital | |
| | Hospital visitor times | |
| | Discharge times | |
| | What to bring | |
| | What to leave at home | |

## Appendix 7 – Perioperative Patient Information Booklet – 2/3

### Arriving at hospital

Car parking is available, however costs may be involved.

The entrance to the car park is at _____ or _____.

When you arrive at the hospital, make your way to _____.

You can find us by:

_____

_____

### What will happen while I wait?

Once you arrive in the Perioperative Unit/Admissions, please go to the reception area.

You may be asked to sit in the waiting room until it is time to have your operation. Sometimes you may notice people going to have their operation before you. People are seen according to their place on the operating list.

Visitors are welcome, but space is very limited, so we ask you bring no more than two people with you.

A nurse and doctor will then ask you questions and take your pulse, blood pressure and weight and you will be asked to change into a hospital gown in preparation for your operation.

### What happens after my operation?

If you are **going home on the same day** you will come back to the Perioperative Unit where you will be given something to eat.

You will be able to leave the hospital once you have recovered from your operation and received your medicines to take home. This is usually between 2-6 hours after your operation. Please make sure you have a responsible adult to take you home and stay with you for the next 24 hours. If this is not possible, please talk with your nurse.

If you are **staying overnight or longer**, you will be taken to a hospital ward. We will tell you which ward on the day of your operation.

### What happens when you go home?

Before you go home, a nurse will help you complete the following information. If you had a day procedure, a nurse from the Perioperative Service may telephone you the next day to check how you are doing.

| | What do I do about: | You should… |
|---|---|---|
| | Pain medicine | Follow the instructions on the packet: _____ |
| | Wounds and dressing | Leave your dressing intact for ___ days. When you shower you should:_____ |
| | Activity | Exercise:_____<br>Lifting:_____<br>Driving:_____<br>Working:_____ |
| | Diet / Food you can eat | _____ diet.<br>Or _____ food. |
| | Toilet | Be aware that pain tablets prescribed after your operation can make you constipated. Contact your GP for advice. |
| | Problems such as bleeding, high temperature, moderate to severe pain | Contact: _____ on (02) ____ ____ and ask for _____. |
| | Follow up appointment | You will need to see:<br>Dr: _____<br>Date: _____ Time: _____<br>Place:_____ |
| | If you have any questions, please ring: | _____ |

## Shared Outcomes Tool – for patient, family and carers

| Ideal outcome | Agreed outcome/s | Notes on outcome/s following surgery/procedure | Outcomes following surgery/procedure discussed with surgeon and anaesthetist | Further comments/notes |
|---|---|---|---|---|
| *This tool records the information and agreed outcomes discussed between you, your family/carer, surgeon/proceduralist and the anaesthetist.* | | | | |
| Surgeon/Proceduralist perspective:<br>e.g. reduced knee pain | Surgeon and patient: | i.e. What was the outcome? | Yes/No<br>Provide details of discussion: | Any other notes on the surgery/procedure or patient journey [relating to outcomes]: |
| Patient perspective:<br>e.g. I want to walk and play golf without pain<br>What I am not prepared to trade/give up in considering having this procedure | Anaesthetist and patient: | | | |
| Anaesthetist perspective:<br>e.g. reduced knee pain | | | | |

**Appendix 8: Patient Information Checklist**

## Appendix 8 – Patient Information Checklist – 1/1

| *The following information may be included when the Perioperative Service team is providing written education and instructions for patients and their carers.* | |
|---|---|
| **Information for patients and their carers should include:** | **Completed** |
| Details of the operation to be performed. | Yes ☐ No ☐ N/A ☐ |
| Expected benefits of the surgery / procedure and risks involved. | Yes ☐ No ☐ N/A ☐ |
| Details of the anaesthetic – e.g. what is a general anaesthetic. | Yes ☐ No ☐ N/A ☐ |
| Appropriate length of stay in hospital. This should include the length of the procedure, as well as the time that the patient will be waiting and/or time that they will be expected to arrive. | Yes ☐ No ☐ N/A ☐ |
| Overview of usual recovery for the patient's procedure including:<br>• When the patient will usually eat and drink<br>• Mobilisation<br>• Return home | Yes ☐ No ☐ N/A ☐ |
| Degree of pain anticipated and how the pain is relieved, e.g. details of techniques such as patient controlled analgesia. | Yes ☐ No ☐ N/A ☐ |
| Approximate time off work needed. | Yes ☐ No ☐ N/A ☐ |
| When will it be safe to resume normal activities e.g. driving. | Yes ☐ No ☐ N/A ☐ |
| The perioperative screener's contact details for the patient and/or carer to ring if:<br>• They cannot attend on the day of surgery<br>• There has been a significant change to their medical condition<br>• Their medication has changed<br>• They need advice. | Yes ☐ No ☐ N/A ☐ |
| What to bring on the day of admission. | Yes ☐ No ☐ N/A ☐ |
| A hospital map, car parking (including costs) and/or other transport arrangements. | Yes ☐ No ☐ N/A ☐ |
| Hospital visiting times for relatives. | Yes ☐ No ☐ N/A ☐ |
| Fasting times and other pre operative preparation. This should include confirming the instructions (and any jargon) are understood e.g. fasting means no food or drink. | Yes ☐ No ☐ N/A ☐ |
| Where relevant, make the patient and/or carer aware of other services, including interpreter, Aboriginal Liaison Officers etc.<br><br>Health facilities must adhere to the NSW Health policy on the use of professional interpreters to support communication with patients, their families and carers from culturally and linguistically diverse backgrounds. See *Interpreters – Standard Procedures for Working with Health Care Interpreters (PD2006_053).* | Yes ☐ No ☐ N/A ☐ |
| Costs attached to the surgery / procedure and/or hospital stay. | Yes ☐ No ☐ N/A ☐ |

*1/1*

**Appendix 9: Standardised Perioperative Pathway**

## Appendix 9 – Standardised Perioperative Pathway – 1/1

| | | | |
|---|---|---|---|
| *Insert LHD/hospital name here* | | Surname: | MRN: |
| | | Given Name(s): | Male ☐ Female ☐ |
| | | D.O.B: / / | M.O: |
| New ☐ Revised ☐ | **Date:** | Address: | |
| | | Location/ward: | |

| | | | |
|---|---|---|---|
| Form completed by: | | | |
| Date: | | | |
| Planned Procedure: | | | |
| Emergency/Elective: | | | |
| Planned Care Pathway: | | | |
| Expected length of stay: | | **Variance:** | |
| Pathway discussed and agreed with the patient: | Yes ☐ No ☐ | Notes: | |

| **Risk assessment – (For ASA IV and V please fax Anaesthetist consultation to GP):** | |
|---|---|
| Patient's ASA Score: | |

| **Perioperative risk management plan includes:** | | **Variance:** |
|---|---|---|
| Pre | | |
| Intra | | |
| Post | | |

| **Anticipated level of care for patients post procedure:** | | | | | **Variance:** |
|---|---|---|---|---|---|
| Day Surgery ☐ | EDO ward ☐ | Ward ☐ | HDU ☐ | ICU ☐ | |

| **Clinical handover from hospital to primary care:** | | | **Variance:** |
|---|---|---|---|
| General Practitioner ☐ | Community Nursing ☐ | Family/Carer ☐ | |

| **Patient requirements for transfer to primary care:** | | | | | **Variance:** |
|---|---|---|---|---|---|
| Transfer of care summary ☐ | Pain Relief / Wean & cease plan ☐ | Nominated carer ☐ | Medications e.g. Warfarin ☐ | Other ☐ | |

| **For ALL variance to the pathway (including RRT calls), DOCUMENT the variance and NOTIFY the Director, Perioperative Service (Anaesthetist) and Nurse Manager. A REVISED PLAN IS REQUIRED.** | | |
|---|---|---|
| Notified to: | | Date: |

| **INFORM GP in the event of an unplanned admission to ICU and/or significant morbidity/mortality:** | | |
|---|---|---|
| Notified to: | | Date: |