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

- **service redesign and evaluation** – applying redesign methodology to assist healthcare providers and consumers to review and improve the quality, effectiveness and efficiency of services
- **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
- **knowledge sharing** – partnering with healthcare providers to support collaboration, learning capability and knowledge sharing on healthcare innovation and improvement
- **continuous capability building** – working with healthcare providers to build capability in redesign, project management and change management through the Centre for Healthcare Redesign.

ACI Clinical Networks, Taskforces and Institutes provide a unique forum for people to collaborate across clinical specialties and regional and service boundaries to develop successful healthcare innovations.

A priority for the ACI is identifying unwarranted variation in clinical practice and working in partnership with healthcare providers to develop mechanisms to improve clinical practice and patient care.

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:

<table>
<thead>
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</tr>
</tbody>
</table>

The Chairperson and the ACI would also like to acknowledge:

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

ACCHS  Aboriginal Controlled Community Health Service
ACI  Agency for Clinical Innovation
APC  Anaesthesia Perioperative Care
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
CQI  Continuous Quality Improvement
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
EGC  Electrolytes, Glucose and Creatinine
EDO  Extended Day Only
ENT  Ear, Nose and Throat
ER  Enhanced Recovery
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
NSW  New South Wales
OSA  Obstructive Sleep Apnoea
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
SST  Surgical Services Taskforce
TCPQ  Transfer of Care Planning Questionnaire

ASA PS Classification - https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system
  - 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
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7.2 Contribution of the Perioperative Service to primary care

7.3 Continuous Quality Improvement

Model of Care 3: “Health Pathways”

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

8.1 Shared decision making

8.2 A perioperative outcomes framework

8.3 Perioperative Patient Information Booklet

8.4 Continuous Quality Improvement

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

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1. 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 services, primary care, 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.

Principles of perioperative care

The underpinning principles of this Toolkit are:

- The patient’s condition is optimised and management of their perioperative risk is supported for the planned surgery/procedure, anaesthesia, and final functional recovery (physical, cognitive, emotional and social).
- The planned surgery/procedure is correct and aligned to outcomes valued by the patient.
- The patient and carer are appropriately informed throughout the perioperative process to enable shared decision making.
- The patient is returned from hospital within the expected time frame.
- The patient is returned to the care of an informed primary health care provider.
- The patient, family, carer and the perioperative multidisciplinary team are satisfied with the patient’s journey.
- The patient journey is safe, adverse events avoided and health outcomes recorded for quality improvement.
- Processes are efficient, duplication minimised and process indicators recorded to inform a system of continuous quality improvement.

Elements of perioperative care

The nine elements of perioperative care described in this Toolkit build upon the original five in its predecessor – the Pre Procedure Preparation Toolkit (PPPT) (2007). The methodology undertaken by the expert Working Group was the Delphi technique1 working with nascent international and local evidence. In particular peer reviewed empirical papers and models of care2,3 were examined.

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 the management of the patient’s perioperative risks associated with their planned surgery/procedure and anaesthesia.
4. The perioperative multidisciplinary team collects, analyses, integrates and communicates information to optimise patient centred care.
5. Each patient’s individual journey should, where appropriate, follow a 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.

The expert Working Group has made the following determination for prioritising further developing the elements of perioperative care:

<table>
<thead>
<tr>
<th>Standard care</th>
<th>Best Practice (to be developed further over the next 5 years)</th>
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<tbody>
<tr>
<td>Elements 1,2,3,4,9</td>
<td>Elements 5,6,7,8</td>
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</table>

It is evident that the four new elements are directed towards the high-risk complex chronic care patient with multisystem disease having moderate to major surgery. The Perioperative Toolkit (2016) acknowledges that the 10 years since its predecessor, the PPPT, has seen significant inroads in addressing elective surgery waiting times by reducing length of hospital stay in healthier patients having less major surgery. The Perioperative Toolkit provides a quality improvement framework to strengthen standard of care and address the healthcare challenges ahead.

**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](#)
- Pre Admission Medical Anaesthetic Assessment Form – [Appendix 4](#)
- Primary Care / General Practitioner (GP) Assessment Tool – [Appendix 5](#)
- Perioperative patient information booklet (PPIB) – [Appendix 6](#)
- Patient information checklist – [Appendix 7](#)
- Standardised Perioperative Pathway (SPP) – [Appendix 8](#)
• Enhanced Recovery or Clinical Pathways for specific surgical procedures

All of these tools can be found on the Perioperative Toolkit page on the [ACI website] and may be customised at the Local Health District (LHD) or Specialty Health Network and/or hospital level to meet local needs.

Key roles and governance

To address the economic challenges of delivering on elective surgery waiting times each NSW Health facility should have an integrated service in place for perioperative care and invest in strengthening their 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 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 operating theatre / procedure room and post-acute care unit.

The medical clinical leader is responsible for:

• 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 initiating quality improvement modifications where required, 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 pre admission clinic triage process, perioperative risk management and prehabilitation, ‘choosing wisely’ when ordering investigations, tests or treatments, fasting times, medications management, integrated pain management and with the surgical procedural team, enhanced recovery clinical pathways, perioperative patient information and criteria for transfer of care.

The nursing clinical leader is responsible for:

• Collaborating closely 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 initiates quality improvement modifications where required, in consultation with the multidisciplinary team.
2. Introduction

In 2007, the Surgical Services Taskforce (SST) commissioned a Working Group to develop the Pre Procedure Preparation Toolkit (GL2007_018). In 2015, the Agency for Clinical Innovation (ACI), Anaesthesia Perioperative Care (APC) Network in collaboration with the SST, commenced a review. Building on previous work, the Perioperative Toolkit (the Toolkit) has been prepared to ensure that the best evidenced care is provided to patients undergoing surgery/procedure and anaesthesia by describing a framework to optimise perioperative structures, processes and outcomes.

This Toolkit was prepared and has been reviewed by frontline clinicians and staff experienced in perioperative care, including anaesthetists, surgeons, nurses, consumers, managers and primary care. An understanding of the fundamental elements of perioperative care has been derived from discussions of the challenges faced by facilities across a spectrum of size, service, location and resources. The Toolkit has taken into account best practice guidelines described in Australian and international literature4,5,6.

3. 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 home or 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.

While the Toolkit is predominantly focussed on perioperative care for the elective patient undergoing surgery/procedure, many of the elements outlined in the document also apply to caring 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 hospitals7.

The perioperative process is the framework of systems, tools and multidisciplinary streams that is essential in ensuring a successful surgical / procedural journey. The perioperative framework is described in this toolkit and is designed for use by all members of the multidisciplinary team involved in patient care. 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.

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7
4. **Summary of key elements**

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<table>
<thead>
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<tbody>
<tr>
<td>1</td>
<td>The perioperative process prepares the patient, family and carer for the whole surgical / procedural journey.</td>
</tr>
<tr>
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<td>All patients require pre admission review using a triage process.</td>
</tr>
<tr>
<td>3</td>
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</tr>
<tr>
<td>5</td>
<td>Each patient’s individual journey should, where appropriate, follow a standardised perioperative pathway.</td>
</tr>
<tr>
<td>6</td>
<td>Measurement for quality improvement, benchmarking and reporting should be embedded in the perioperative process.</td>
</tr>
<tr>
<td>7</td>
<td>Integration with primary care optimises the patient’s perioperative wellbeing.</td>
</tr>
<tr>
<td>8</td>
<td>Partnering with patients, families and carers optimises shared decision making for the whole perioperative journey.</td>
</tr>
<tr>
<td>9</td>
<td>Effective clinical and corporate governance underpins the perioperative process.</td>
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</table>
5. 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 with the patient 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. This process must take place in collaboration with other specialties and hospital processes that also support an efficient and safe patient journey.

Diagram 1: The perioperative process

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

The clinical reasoning 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)) or the intensive care unit (ICU). High Volume Short Stay Surgical (HVSSS) wards are dedicated areas that look after surgical DOS, EDO admissions as well as hospital stays up to 72 hours. Some of these – for example EDO and HVSSS – have specific NSW Health guidelines.

Planning for transfer of care from hospital back to primary care similarly triages community resources to patient need. In other words, by applying the principles and tools in this Toolkit, patient needs are communicated and aligned with the necessary resources.

1.1 Health and social summary for the surgery/procedure

The patient’s health and social status at the time of finalisation of pre procedural preparation should be documented and dated in a summary using a consistent format and available to be used
by all health professionals caring for the patient at the time of the surgery/procedure and in the event of unexpected complications. The details of the surgery/procedure and plan of care should also be documented and dated in a consistent format and available to all health professionals caring for the patient. The complexity and detail of the health summary and surgical/procedural information will be influenced by the complexity of both the patient's health status and the inherent risks of the planned surgery/procedure.

Where possible, the summary should 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.
Diagram 2: What does perioperative care deliver?

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

**Patient**
- Preferences
- Expectations
- Addresses concerns

**Medical Information**
- Health status
- Social support
- Recent investigations

**GP/Primary Care**
- Addresses concerns
- Expectations

**Anaesthetic Requirements**
- Equipment
- Assistant for procedures outside theatres
- Technical backup for high-risk patients

**Surgical Requirements**
- Equipment
- Other resources

**Hospital**
- Resources
- Ministry of Health targets
- Process indicators & health outcomes

Collation, analysis, documentation and integration of information to optimise care for each patient.
Element 2: All patients require pre admission review using a triage process

All patients require pre admission review using a Patient Health Questionnaire (PHQ) triage process but not all patients may need investigations or to attend a PAC.

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 in determining whether additional investigations or processes are needed based on the patient’s level of medical and surgical risk.

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

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.

### 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 Transfer of Care from Hospital Planning Questionnaire (TCPQ) to the patient and carer. The RFA must include the minimum information outlined in the NSW Health [Waiting Time and Elective Surgery Policy](#).

**Diagram 4: Time to surgery**

![Diagram 4: Time to surgery](image)

### 2.2 PHQ review and triage

The 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 and the nature and complexity of the surgery/procedure. It may also indicate the scheduled or anticipated date for the surgery/procedure and the length of stay. The complete triage process should be completed at

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8 NSW Health, Waiting Time and Elective Surgery Policy (PD2012_011), 8. (Currently being revised)
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 day only surgery – PHQ and TCPQ review may be necessary several months prior to the surgery/procedure for collaborative prehabilitation in primary care.

A PHQ is the foundational tool for pre admission triage. The information provided on this questionnaire provides the necessary details for the screener to make a decision regarding the level of further pre admission assessment required.

In addition to the PHQ, there are a range of other tools or sources for gathering information about the patient’s medical condition. This may include existing records from a previous hospital visit, primary health care providers, surgeons or specialist physicians.

**Box 1: The PHQ should elicit essential elements of the patient’s medical history**

<table>
<thead>
<tr>
<th>This should include:</th>
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<tbody>
<tr>
<td>• basic demographic details including age, weight, height, sex and Aboriginal and/or Torres Strait Islander status</td>
</tr>
<tr>
<td>• previous and current medical conditions</td>
</tr>
<tr>
<td>• previous surgery or hospital admissions</td>
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<tr>
<td>• current medications</td>
</tr>
<tr>
<td>• allergies</td>
</tr>
<tr>
<td>• past experience with anaesthesia</td>
</tr>
<tr>
<td>• family history</td>
</tr>
<tr>
<td>• general fitness, exercise tolerance</td>
</tr>
<tr>
<td>• social history including smoking, alcohol and other drug use</td>
</tr>
<tr>
<td>• relevant transfer of care planning information</td>
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Examples of these tools: PHQ – Adult (Appendix 1) and PHQ – Paediatric (Appendix 2) are available in the appendices or on the [ACI website] and can be adapted to meet local needs.

When an incomplete PHQ is received, action should be taken to complete the PHQ by a clerk or nurse. This may be by mail or telephone and where appropriate, may involve the primary health care provider.

2.2.1 TCPQ triage

Screening for transfer of care home from hospital is done simultaneously with PHQ triage using the TCPQ. 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, or prompt review or assistance from a member of the multidisciplinary team. This may include interpreters, physiotherapists, pharmacists, occupational therapists, speech pathologists, dietitians, podiatrists and social workers who are consulted according to procedure specific and social circumstances. Ultimately, this tool should complement the information identified on the RFA and PHQ.
The TCPQ (Appendix 3) should be completed and reviewed at the same time as the PHQ. The NSW Health Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Policy Directive (PD2011_015) outlines requirements for all NSW public hospitals. An accompanying Reference Manual provides further advice and example tools.

All patients require individual planning. Therefore, a key part of the perioperative process is planning for the patient’s transfer of care from hospital. The planning for transfer of care tool is often supplemented by a telephone call from a PPP/ PAC nurse.

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 for the complete perioperative journey.

Based on established local guidelines, the clinical screener reviews each completed questionnaire and the clinical information on 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 (see Model of Care 1). Model of Care 1 is long standing at one NSW teaching hospital and may be adapted as a template for triage.

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. day only or extended day only) 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.

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

**Box 2: Information discussed via phone with the patient and/or carer on the working day prior**

- Current health status
- Smoking
- Medication management
- Results/x-ray
- Fasting instructions for food and drink
- Arrival time
On the day of surgery/procedure the patient will have a final assessment for fitness for surgery/procedure with their procedural anaesthetist.

2.3.2 Comprehensive telephone interview required

This can apply to patients described above, but where additional communication is required due to doubt regarding their functional capacity or social needs e.g. language or communication difficulties. A telephone interview to source more information from the patient (or carer) and/or primary health care provider may be required.

2.3.2.1 Obtaining additional information from the primary health care provider and/or specialists

Where appropriate, the following information should be sought:

- A Health Summary.
- Results from 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.
- Copies of the recent letter/s from the patient’s specialists.
- Details of any anaesthetic complications the patient may have had and any allergy testing that might have been done.

Where the primary health care provider is not able to provide relevant specialist information the specialist should be contacted directly for this information.

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 as in 2.3.1.

2.3.3 PAC attendance required in person or via Telehealth

2.3.3.1 A general PAC is generally conducted by a team of an anaesthetist, nurse, medical officer (surgery team) and clerk. A general PAC is necessary where further 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
- 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 health care 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 health care provider) requests PAC.

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
• Allied Health
• Primary health care provider
• professional interpreter services, multicultural or diversity health units or Aboriginal liaison services.

When the general PAC team determine that no further assessment is required, the patient and carer are provided with written and telephone education and instructions as outlined earlier 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 the [ACI website](http://aci.health.nsw.gov.au).
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 to surgery / procedure

Pathway Two
ASA II-IV having moderately to highly invasive surgery / procedure
- As for Pathway One, plus general pre admission clinic visit required
- Includes anaesthetist, surgeon and RN

Pathway Three
Patients having moderate 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 as needed, 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 and the Surgery for Children in Metropolitan Sydney: Strategic Framework. A list of further reading on NSW Health requirements for paediatric surgery is 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 3: 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 role of parents, guardians and carers is important and should be supported with appropriate education.
- Proactive measures such as 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.

2.5 Developing local guidelines for triage and risk assessment

Local guidelines should be established for Element 2 (examples are available on the ACI website).

Within each service:

2.5.1 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 the 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 the appropriate ordering of perioperative investigations and tests should be established.

Choosing Wisely Australia has developed a range of resources to assist healthcare professionals and consumers in discussing and determining appropriate perioperative testing – more information is available at http://www.choosingwisely.org.au/.
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. The American Society of Anesthesiologists similarly recommends against baseline testing for low risk patients having a low risk procedure. This applies to simple blood investigations including full blood count (FBC), electrolytes, glucose and creatinine (EGC), calcium, magnesium, phosphate (CMP), coagulation studies, blood group and screen, ECG, chest x-ray (CXR). The AHA/ACC advise against preoperative cardiac testing in patients with a low calculated risk of perioperative major adverse cardiac event (MACE). 

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 local preoperative testing guidelines.

Preoperative tests provide a benefit where they:

- yield additional information that cannot be obtained from a patient history and physical examination alone
- 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 should be established.

- If there is no local protocol, general preoperative fasting advice is available on the ACI website.

2.5.4 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.

2.5.5 Enhanced Recovery or Clinical Pathways should be established (see Element 5 for more information).

Pre procedure guidelines should also specify:

- Timelines for the triage process.

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• Who is responsible for reviewing and actioning results of investigations.
• The standardised information to be given to patients and 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 pre admission clinic / pre procedure processes.
Element 3: Pre procedure preparation (PPP) optimises and supports the management of the patient’s perioperative risks associated with their planned surgery/procedure and anaesthesia

PPP 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 health care providers and includes access to other services as necessary.
- ensuring that, where possible, the expectations of the patient, family, carer, the surgeon / proceduralist, procedural anaesthetist and primary health care provider are all met.

3.1 Further aspects of triage and examples of risk assessment tools

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

The American Heart Association and American College of Cardiologists (AHA/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 major adverse cardiac event (MACE) of death or myocardial infarction of <1%. 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.12

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 testing13 or cardiopulmonary exercise testing (CPX).

Precise calculation of perioperative risk may have implications for informed consent for surgical procedures, or for perioperative planning, particularly with regard to postoperative destination (high

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dependency or intensive care unit placement)\(^\text{14}\). 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\(^\text{15}\). There are a number of tools that can be used to assess perioperative mortality risk – examples include \textit{NSQIP Surgical Risk Calculator}, P-POSSUM\(^\text{16}\) and the \textit{Surgical Outcome Risk Tool}.

Choosing Wisely Australia has developed a range of resources to assist healthcare professionals and consumers in discussing and determining appropriate perioperative testing and treatment options – available at \texttt{http://www.choosingwisely.org.au/}.

However, not all perioperative adverse outcomes are cardiac. Specific areas of medical risk include patients with complex multisystem chronic disease. Table 1 lists a range of conditions or risk areas that should be considered as part of the patient’s perioperative risk assessment.

\begin{table}[h]
\centering
\begin{tabular}{|l|l|}
\hline
\textbf{Condition / Consideration} & \textbf{Further Reading / Reference Guidelines} \\
\hline
Poor or indeterminable cardiorespiratory reserve or exercise tolerance & As above references \\
\hline
\hline
Obstructive sleep apnoea (OSA) & STOPBang Questionnaire \texttt{http://www.stopbang.ca/osa/screening.php} \\
\hline
Renal function & Renal Society guidance \\
\hline
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. \\
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3.2 The role of different health care professionals

The following sections look at the roles of different health specialists during PPP in optimising the patient’s condition and their hospital and primary care context for their planned surgery/procedure.

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 already been done).
- Discusses and decides on appropriate perioperative testing with the patient, family and 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 generally and for anaesthesia, integrated pain management and the patient’s perioperative care plan.
- 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 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 requirements e.g. smoking cessation, reducing alcohol intake, managing poor blood glucose control.
• Explains the processes that will be followed 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 be with them on the first postoperative night.¹⁷

• Seeks further information and where necessary makes referral to other specialists e.g. cardiologist, respiratory physician, endocrinologist, renal physician, haematologist, geriatrician 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 Australia has developed a range of resources to assist healthcare professionals and consumers in discussing and determining appropriate perioperative testing and treatment options – available at http://www.choosingwisely.org.au/.

• Communicates directly with the procedural anaesthetist as appropriate.

• Communicates directly with the 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 4 or can be found on the [ACI website].

3.2.2 The primary health care provider e.g. GP 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). An example – Primary Care / GP Assessment Tool is at Appendix 5 or is available 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. Choosing Wisely Australia has developed a range of resources to assist healthcare professionals and consumers in discussing and determining appropriate perioperative testing and treatment options – available at http://www.choosingwisely.org.au/.

• 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.

¹⁷ Australian and New Zealand College of Anaesthetists, 2010. PS15: Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery.
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 sub specialty nurses and allied health clinicians.
- Coordinates PAC and the attendance of the appropriate members of the multidisciplinary team as needed.
- 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. An example – Perioperative Patient Information Booklet (Appendix 6) and Patient Information Checklist (Appendix 7) – are also available on the [ACI website].
- Facilitates planning for and case manages the actual transfer of care from hospital by as needed referral to allied health, subspecialty surgical and other services such as the Aboriginal Controlled Community Health Service (ACCHS).
- Communicates information to surgical / procedural and anaesthetic teams as required.

3.3 The expectations of patients, procedural anaesthetist, surgeon / 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 on how their surgery/procedure is allocated and scheduled.
- The patient and carer must be provided with full information about their surgery/procedure, as well as the anaesthesia and recovery and their transfer of care from hospital to facilitate shared decision making and informed consent.
- The patient, family and carer should understand their:
  - admission details
  - fasting time
  - how to manage medications
  - 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 health care team.

3.3.2 Procedural anaesthetist and surgeon/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 appropriate 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.

- That there is a continuous quality improvement process where process indicators and health
  outcomes of patients are provided and fed back to the health care team in a timely manner.
Element 4: The perioperative multidisciplinary team collects, analyses, integrates and communicates information to optimise patient centred care

As the Perioperative Toolkit builds upon its predecessor the PPPT (2007), its quality framework builds upon the resources – structures and processes – including the human resources already in existence in NSW Health facilities.

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

The members of the broader multidisciplinary team, the hospital and the District or Network, should have the expectation 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, primary health care providers, specialist physicians – are consulted as appropriate, for all patients having more major surgery and/or with significant comorbidities or in the case of variance to planned care or an adverse event. All team members contribute to an optimal perioperative journey (Diagram 5).

At different stages of the patient’s surgery / procedural journey, different team members more closely provide patient centred care:

- Before and after hospital admission it is the primary healthcare providers who provide patient centred care.
- During the most critical phase of care – intraoperative - it is the senior surgeon, the procedural anaesthetist and the operating theatre nursing team.
- For this reason, 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 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 all members of the perioperative team including the broader multidisciplinary team can be called upon as needed 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 health 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 for the complete perioperative journey. At all stages the patient information needs to be checked for consistency e.g. the RFA, the consent form, the correct site for surgery, medications. All members of the multidisciplinary team are responsible for checking patient information.
Diagram 5: The multidisciplinary team

- Anaesthetist
- Nurse
- Surgeon/proceduralist
- Medical officer with surgical team
- Subspecialty CNCs
- Allied health
- Other medical specialists
- Primary care (GP, ACCHS)
- Clerks
- Patients, carers and families
Element 5: Each patient’s individual journey should, where appropriate, follow a standardised perioperative pathway

5.1 The Standardised Perioperative Pathway (SPP)

The SPP is the first new tool of The Perioperative Toolkit. The SPP is a communication tool for all in 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 care to be marked for timely clinical attention for continuous quality improvement (CQI). The SPP takes into account a patient’s medical status – complex chronic multisystem disease – and perioperative risk as well as the impact of the patient’s surgery/procedure – as outlined in the patient’s Enhanced Recovery (ER) or Clinical Pathway (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 pre procedure preparation.
- The SPP should be discussed and agreed with the patient.
- Be placed before the clinical notes section of each patient’s medical records for easy viewing and reporting of variance.
- Wherever possible and appropriate, for the anticipated surgery/procedure an Enhanced Recovery or Clinical Pathway should be attached to the SPP.
- A risk assessment based on the ASA Score is documented.
- The pre, intra and postoperative risk management plan should be documented as appropriate.
- Anticipated time and place 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 to primary care.
- Variance to anticipated process indicators and health outcomes 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 CQI, including Rapid Response Team (RRT) calls.
- Ideally, this information, including the variance, will be recorded on the tool by the medical officer of the surgical team or 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 health care 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 Surgery/procedure considerations – Enhanced Recovery (ER) and Clinical Pathways (CP)

Procedure specific ER or CPs are bundled care tools designed to improve the continuity and coordination of care, particularly where different specialties, disciplines and sectors 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\(^\text{18}\).

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\(^\text{19}\).

Ultimately, 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. More information on examples of LHD Enhanced Recovery pathways are provided on the [ACI website].

5.3 The Standardised Perioperative Pathway (SPP) plus the Enhanced Recovery (ER)/Clinical Pathways (CP)

Where possible, information relevant to the patient’s surgery/procedure should all 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 also ensure there is one agreed location or a ‘one stop shop’ where all members of the clinical team can find information on the patient’s planned perioperative journey or any variance.

This SPP plus the ER / CP:

- acts as a prompt for the key steps in the perioperative process
- ensures that the management of the patient’s perioperative journey continues until their transfer of care from hospital
- guides 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 and consultation 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 8 and can also be downloaded from 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, particularly where the intended outcome shows variance. At the outset, Sam (green) is healthy ASA 1. Sandy (blue) 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 to his SPP requiring unplanned HDU (also known as COU) admission, documentation and timely notification to the clinical leads – medical and nursing – are required and also notification of the patient’s GP. A revised SPP is required for Sam and possibly although not necessarily revisions to his enhanced management pathway as well.
Model of Care 2: The Standardised Perioperative Pathway using a total knee replacement pathway at one hospital

In this example, two patient journeys via an enhanced management total knee replacement pathway – for Sam (green) and Sandy (blue) – are represented on the SPP tool.

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Agency for Clinical Innovation | CONSULTATION DRAFT: The Perioperative Toolkit
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 or procedure;
  - in an appropriate timeframe
  - that complications are minimised
  - the patient returns home safely.

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
- individual clinicians
- clinical teams
- the organisation at both the hospital and district level
- 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
- research
- performance reporting – to the District/Network or Ministry of Health
- 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 (outlined in Element 8).
In selecting perioperative process measures, performance indicators and health outcome measures, these should be aligned whenever possible with the ACI's Operating Theatre Efficiency Guidelines (2014). The latter outlines a minimum set of metrics that should be reviewed in monitoring and measuring operating theatre (OT) performance\(^{20}\) and are available on the ACI website.

### 6.2 Performance indicators

Process or performance indicators should be monitored monthly. Many of these indicators are collected monthly and reported on the Surgical Service Taskforce Dashboard. Suggested indicators for review in the context of the Toolkit may include:

- % preventable cancellations on the day of surgery
  - 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/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 by documenting the key elements of a SPP. Model of Care\(^{2}\) outlines an example of two patients and their subsequent variance from the perioperative care pathway.

### 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.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Metric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survival</td>
<td>30 day mortality 90 day mortality</td>
<td>% Rapid Response Team calls within 24 hrs post-operative % Unplanned admission overnight % Unplanned admission to</td>
</tr>
<tr>
<td>Recovery</td>
<td>Complications</td>
<td></td>
</tr>
</tbody>
</table>

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

There should be a systematic approach to collecting perioperative data about the outcomes of interventions. Key points include:

- Where possible this should 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 at [www.ichom.org](http://www.ichom.org)) recommend minimum data sets.
- Data definitions must be precise to allow accurate analysis and benchmarking.

The 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) 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 can then use the NSQIP analysis to inform hospital base quality improvement.

The ACI Surgical Services Taskforce is supporting implementation at four pilot sites in NSW. More information is available on the [ACI website](http://www.achom.org).
Diagram 6: Measurement Cycle

Collect data that is valued by patients and clinicians and analyse variation

Consider how to improve measurement for continuous quality improvement

Disseminate monthly outcomes reports to clinicians

Facilitate discussion to identify best practice

Plan how to improve
Do the improvement
Study the results
Act to address further improvement needs
Element 7: Integration with primary care optimises the patient’s perioperative surgical or procedural wellbeing

The Perioperative Toolkit acknowledges that before and after hospital admission, it is the primary health care providers who provide patient centred care. Furthermore, primary care providers have a key role in the patient’s perioperative journey. The relationship between a patient, (family and carer) and their primary care provider (e.g. GP or ACCCHS) often encompasses many years and perioperative teams should take advantage of the primary care 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 significant and multifaceted:

- Supporting 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. Example Primary Care/GP Assessment tool is at Appendix 5.
- Provides advice to the Perioperative Service on the expectations of the patient, family, carer, GP and other clinical specialists for the surgery/procedure.
- Is involved in preoperative assessment and risk stratification of the patient.
- Collaborates with the Perioperative Service for the diagnosis and optimisation of all medical comorbidities or risk factors and prehabilitation where appropriate for:
  - Patients with chronic complex multisystem disease
  - Elderly patients
  - Frail patients
  - Patients with metabolic syndrome
  - Supporting the patient to modify their lifestyle e.g. smoking cessation, weight loss, exercise
  - 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.
- Provides investigation/test results to the perioperative team in a timely fashion. This is facilitated by providing a single point of contact for the delivery (electronic, hard copy or fax) of reports for appropriate distribution across the perioperative team.
- Pre and postoperative medication optimisation and administration e.g. de-warfarinisation, enoxaparin administration and re-warfarinisation.
- Supporting 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 information with the patient’s primary care provider is an essential element of standard perioperative care. One of the key features of the standardised perioperative pathway (SPP) is to ensure that information relating to the patient’s perioperative journey is provided to the primary health care provider for all patients. See Element 5.

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

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

Consideration should also be given to whether the patient may require access, or was already under the care of additional services, 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 accurately and directly to enable primary care 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 care provider is notified by the hospital’s Perioperative Service of a significant variance in hospital 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

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requirements for pain, transfer from home to a 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)22, there is great potential for broadening current inpatient clinical pathways into perioperative pathways. These pathways delineate the responsibilities of the patient, their primary care provider, the surgeon, anaesthetist and other members of the perioperative team in the perioperative period. Central to this is improved communication between multidisciplinary members of the patient’s health care 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 Local Health Districts.

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 and questions that may be useful for discussion in perioperative team meetings. This resource is available 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\(^\text{23}\).


8.1.1 Health literacy and decision support aids

In considering the most appropriate support aids, staff working in the Perioperative Service must always be aware of the patient and carer’s level of health literacy. This is particularly important when communicating perioperative risks to the patient and carer\(^\text{24,25}\).

More information to support to clinicians, health services and consumers are available on the Australian Commission for Safety and Quality in Health Care website and the CEC website. In NSW health services, where the patient and/or carer are from a culturally or linguistically diverse background, the NSW Health policy\(^\text{26}\) 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.

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 7):

- Actively engages patients carers families and clinicians in considering:
  - their information needs pre, intra and post surgery/procedure


their desired outcomes for the surgery/procedure.

- On the left hand side of the diagram are the steps of the patient journey.
- On the top row are the perspectives and 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 / not to bring
  - Tests and medications
  - Expected length of stay.
- 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 will 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 6 for patients, families and carers to document the discussion regarding the perioperative outcomes framework – see 8.2.

A Patient Information Checklist – Appendix 7 – is another tool for clinicians and patients, families and carers for ensuring all the relevant information has discussed.

Appendices 6 and 7 are also available 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 will assist health services in CQI through learning from their patients’ experiences.
Diagram 7: Outcomes framework for the patient journey

<table>
<thead>
<tr>
<th>Patient journey</th>
<th>Patient perspective</th>
<th>GP perspective</th>
<th>Surgeon perspective</th>
<th>Anaesthetist perspective</th>
<th>Organisational perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Decision to surgery – discussion re shared outcomes</strong></td>
<td>Communication (risks, survival, opportunity to communicate ideal outcome to surgeon, perioperative pathway)</td>
<td>Agree plan with patient for surgery including intended outcomes, as well as risks and adverse outcomes</td>
<td></td>
<td>Patients requiring a PAC referred at an appropriate time before surgery</td>
<td>Waiting list categories</td>
</tr>
<tr>
<td></td>
<td>Access to professional interpreter if needed</td>
<td></td>
<td></td>
<td>All patients triaged</td>
<td>Access to relevant services provided for patients/carers e.g. professional interpreter, Aboriginal liaison</td>
</tr>
<tr>
<td><strong>Preoperative preparation – General (Surgery/procedure specific to be determined locally, by procedure)</strong></td>
<td>Waiting time</td>
<td></td>
<td></td>
<td>Agreed plan for perioperative journey/pathway</td>
<td></td>
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<tr>
<td></td>
<td>Explanation/communication of planned perioperative pathway</td>
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<tr>
<td><strong>Intraoperative</strong></td>
<td>Planned procedure is undertaken</td>
<td></td>
<td>(Preventable) cancellations on day of surgery</td>
<td>(Preventable) cancellations on day of surgery</td>
<td>Cancellations on day or surgery</td>
</tr>
<tr>
<td></td>
<td>Anaesthesia or sedation is appropriate</td>
<td></td>
<td>Clinical outcome achieved</td>
<td></td>
<td>Abandoned procedures</td>
</tr>
<tr>
<td></td>
<td>Procedure is safely and successfully completed</td>
<td></td>
<td></td>
<td></td>
<td>Waiting list requirements</td>
</tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mortality</td>
</tr>
</tbody>
</table>
| Postoperative care in hospital | • Pain management  
• Mobility  
• Length of stay  
• Patient experience  
• Agreed clinical outcome achieved  
• Quality of recovery | • Unplanned admission to ICU  
• Serious morbidity / mortality | • Complications e.g. unplanned admission to ICU, unplanned return to theatre, infection.  
• Length of stay  
• Deviation from ERAS pathway | • RRT calls  
• Unplanned admission to ICU  
• Deviation from planned perioperative pathway | • Mortality  
• Length of stay |
|---|---|---|---|---|---|
| Transfer of care from hospital to the community | • Where to: Home / residential care etc  
• Care information communicated to patients and carers  
• Recovery: Time to return to work/lifestyle  
• Access to other services e.g. professional interpreter, Aboriginal liaison | • Transfer of care communicated to GP  
• Integrated pain management e.g. S8 scripts | • Readmission | • Readmission  
• Integrated pain management | • Readmission  
• Mortality  
• Access to relevant services provided for patients/carers e.g. professional interpreter, Aboriginal liaison |
| Care in the community | • Access to advice where needed  
• Follow up from hospital / with GP  
• Quality of recovery | | | | |
Element 9: Effective clinical and corporate governance underpins the perioperative process

To address the economic challenges of delivering on elective surgery waiting times each NSW Health facility should have an integrated service in place for perioperative care and invest in strengthening their model of care.

Clinical and corporate governance:
- requires coordination and investment
- is critical at the District/Network, hospital/facility and Perioperative Service levels.

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.

<table>
<thead>
<tr>
<th>Governance</th>
<th>Activities / Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Health District / Specialty Health Network</td>
<td>• Provides executive sponsorship for the continuing development of Perioperative Services.</td>
</tr>
<tr>
<td></td>
<td>• Ensures local processes and tools meet the clinical and administrative needs of the patient during their perioperative journey.</td>
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<tr>
<td></td>
<td>• Directly engages and supports frontline clinical leaders in this task.</td>
</tr>
<tr>
<td>Hospital/facility</td>
<td>• Identifies a frontline clinician to be the Director, Perioperative Service and that, wherever possible, this medical clinical lead is an anaesthetist.</td>
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<tr>
<td></td>
<td>• Partners the medical clinical leader with a nurse clinical leader for the Perioperative Service.</td>
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<tr>
<td></td>
<td>• Supports the Director, Perioperative Service to engage local surgeons, anaesthetists and other key stakeholders in ensuring that perioperative structures, processes and outcome measures are well established to ensure patients are optimally prepared for their surgery/procedure and perioperative journey.</td>
</tr>
<tr>
<td></td>
<td>• Supports the establishment of the frontline Perioperative Service made up of anaesthetists, nurses, clerks along with the broader multidisciplinary team members.</td>
</tr>
<tr>
<td></td>
<td>• 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.</td>
</tr>
<tr>
<td>Perioperative Service</td>
<td>• The Director, Perioperative Service together with hospital/facility management, establishes the leadership team of senior anaesthetist/s and nurse/s to:</td>
</tr>
</tbody>
</table>
Develop the service framework including local systems and processes, integration with primary care, partnering with patients.

- Identify the frontline and broader multidisciplinary perioperative team members.
- Liaise with and facilitate the work of key stakeholders also responsible for the surgical / procedural patient journey.

- Takes responsibility for supervising the collection, reviewing and managing of process indicators and health outcomes for individual patients and for the service.

Diagram 8: Clinical and corporate governance

- Local Health District / Specialty Health Network
  - Executive Sponsorship

- Hospital
  - Clinical Leads
  - ~ Medical (Anaesthetist) ~
  - ~ Nursing ~

- Perioperative Service
  - Elements
  1. Perioperative process supports the surgical/procedural journey
  2. Pre admission review and triage
  3. Pre procedure preparation
  4. Multidisciplinary team
  5. Standardised Perioperative Pathway / Enhanced Recovery or Clinical Pathways
  6. Measuring for quality improvement
  7. Integration with primary care
  8. Partnering with patients
6. 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.


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.

7. Reference List and Further Reading


Agency for Clinical Innovation, 2015. Guidelines for the use of Telehealth for Clinical and Non Clinical Settings in NSW.


NSW Health Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals Policy Directive (PD2011_015)


NSW Health Emergency Surgery Guidelines (GL2009_009)

NSW Health, Extended Day Only Admission Policy (PD2011_045)

NSW Health, High Volume Short Stay Surgical Model Toolkit (GL2012_001)


Paediatric References


8. Appendices

All tools referenced in this toolkit are available for download on the [ACI website].

Appendix 1: Patient Health Questionnaire – Adult

**PATIENT HEALTH QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Name/Known as:</th>
<th>Surname</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given Name</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>D.O.B. <strong>/</strong>/____</td>
<td></td>
<td>M.O.</td>
</tr>
<tr>
<td>Address</td>
<td>Location/ward</td>
<td></td>
</tr>
<tr>
<td>Are you of Aboriginal or Torres Strait Islander origin? No □ Yes, Aboriginal □ Yes, Torres Strait Islander □</td>
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</table>

Please answer the questions by ticking the applicable boxes. 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 doctors in the last 5 years? If yes, please list:
   Reason for seeing Dr | Dr’s name | Dr’s Phone Number | Last visit (date)

4. Do you use any regular medications? (e.g. pills, puffers, herbal, bush medicine and non-prescribed medications). No □ Yes □
   If yes, please list:
   Medication/dose | When taken | How often

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

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

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
   - 2 flights stairs
   - Half a flight of stairs
   - Around the house

Office Use Only – PHQ TRIAGE INSTRUCTIONS
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>When</th>
<th>How often</th>
<th>What type</th>
<th>List</th>
<th>What condition</th>
<th>If No, relationship to patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have any difficult opening your mouth or have limited neck movement?</td>
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<td>Have you had any recent anaesthetics (including at the dentist)? If yes when was the last one?</td>
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<td>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?</td>
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<tr>
<td>High blood pressure</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Chest pain or 'angina'</td>
<td>Yes</td>
<td>No</td>
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<td>Heart attack</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Any other heart condition e.g. heart valve, pacemaker</td>
<td>Yes</td>
<td>No</td>
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<td>Lung problems needing hospital</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Troublesome shortness of breath</td>
<td>Yes</td>
<td>No</td>
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<td>Chronic bronchitis</td>
<td>Yes</td>
<td>No</td>
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<td>Asthma</td>
<td>Yes</td>
<td>No</td>
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<td>Should you be using a puffer (e.g. Ventolin)?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Other lung or breathing problems (e.g. sleep apnoea)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Reflux of acid or food – heartburn / hiatus hernia</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Diabetes</td>
<td>Yes</td>
<td>No</td>
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<td></td>
<td>Insulin (Y/N); Diabetic Tablets (Y/N):</td>
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<tr>
<td>Epilepsy or fits</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Stroke</td>
<td>Yes</td>
<td>No</td>
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<td>Blackouts or fainting</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Blood clots or a bleeding disorder</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Anaemia</td>
<td>Yes</td>
<td>No</td>
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<td>Previous blood transfusion</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Kidney condition</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Hepatitis or liver condition</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Has your doctor prescribed you Prednisone, cortisone or other steroids?</td>
<td>Yes</td>
<td>No</td>
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<td>Is there a condition that runs in the family e.g. thalassemia, muscle dystrophy?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Do you have any other health issues not mentioned above e.g. hormone therapy, poor teeth, rheumatoid arthritis?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>An infectious disease (e.g. 'golden staph', HIV, TB)?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Are you pregnant?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Do you smoke?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>Do you drink alcohol?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Have you completed this questionnaire yourself?</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of person completing the form: ____________________________
Date: ____________________
### 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 _____________.

<table>
<thead>
<tr>
<th>Surname</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Given Name</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D.O.B. (dd/mm/yyyy)</th>
<th>M.O.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address

<table>
<thead>
<tr>
<th>Location/ward</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

**COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE**

Age:

Weight:

Height:

Planned procedure:

Are you the legal guardian? No [ ] Yes [ ]

Are you of Aboriginal or Torres Strait Islander origin? No [ ] Yes, Aboriginal [ ] Yes, 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).

3. Has your child 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:
   
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 doctors? If yes, please list.
   Reason for seeing Dr: Dr's name: Dr's Phone Number: Last visit (date): No [ ] Yes [ ]

6. Does your child use any regular medications? (e.g. pills, puffers, herbal, bush medicine and non-prescribed medications). If yes, please list below.
   Medication/dose: When taken: How often: No [ ] Yes [ ]

---

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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:

   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 apnoeoa): 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 meases, 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:
## Appendix 3: Transfer of Care from Hospital Planning Questionnaire

### TRANSFER OF CARE FROM HOSPITAL PLANNING QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Name/Known as:</th>
<th>Surname</th>
<th>MRN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Given Name</td>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>D.O.B.</td>
<td>M.O.</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Location/ward</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you of Aboriginal or Torres Strait Islander origin?
- Yes, Aboriginal
- Yes, Torres Strait Islander
- No

### Dear Patient,

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 boxes. If you require help, ask you family, local doctor or phone ________________

### 1. Age ______________
### 2. Do you speak English at home? If no, which language do you speak?
- No
- Yes

### 3. Do you need an interpreter?
- No
- Yes

### 4. What is your understanding of how long you will be in hospital?
- Day only
- Overnight
- 1-2 days
- 2-5 days
- Unsure
- > 1 week

### 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

### 6. Do you live:
- Alone
- With family
- With carer
- Nursing home
- Hostel
- Other: _______________

### 7. Where do you live:
- House/unit
- Boarding house
- Hostel

### 8. Do you care for another person on a regular basis?
- No
- Yes

### 9. Have alternative arrangements been made to look after this person?
- No
- Yes

### 10. Do you normally need assistance to walk?
- No
- Yes

### 11. Do you use a walking aid such as a stick or frame? If yes, what type?
- No
- Yes

### 12. Do you have stairs at home?
- If yes, how many and are they indoors/outdoors:
- No
- Yes

### 13. Do you have difficulties with your sight? Please describe:
- No
- Yes

### 14. Do you have any difficulties with your hearing? Please describe:
- No
- Yes

---

### Office Use Only

| Yes? Action: | Book Interpreter □ |
| Is this correct? | Y □ N □ Action |
| No? Action: | Contact patient □ |
| Alone, boarding house, hostel? Action: | Contact patient □ |
| Yes, then No? Action: | Look at procedure |
| Yes? Action: | Look at procedure |
| Yes? Action: | Look at procedure |
14. On discharge, do you think you will have any problems with:

- Bathing / showering
- Dressing
- Toileting
- Cooking
- Cleaning
- Shopping
- Business matters
- Family matters

Other: __________________________ Describe:

15. On discharge, do you think you will require help at home (that cannot be provided by the person escorting you home—see question 5)?

- No [ ] Yes [ ]

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**

<table>
<thead>
<tr>
<th>Expected length of stay</th>
<th>Actions completed</th>
<th>Intervention required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>No [ ] Yes [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone intervention</th>
<th>No [ ] Yes [ ]</th>
<th>Action:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Screened by: (RN)</th>
<th>Signature:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Referrals to be made to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social work [ ]</td>
</tr>
<tr>
<td>CNC Discharge liaison [ ]</td>
</tr>
<tr>
<td>Physiotherapy [ ]</td>
</tr>
<tr>
<td>Stomal therapy [ ]</td>
</tr>
<tr>
<td>Occupational therapy [ ]</td>
</tr>
<tr>
<td>CAPAC [ ]</td>
</tr>
<tr>
<td>D&amp;A [ ]</td>
</tr>
<tr>
<td>ALO [ ]</td>
</tr>
<tr>
<td>Interpreter [ ]</td>
</tr>
</tbody>
</table>

Other: [ ] Describe: __________________________

Requires Pre Admission Clinic [ ]

Appointment made by (administrative staff): Signature: Date: |

Appointment date:
Appendix 4: Pre Admission Medical Anaesthetic Assessment Form

Pre-Admission Medical-Anaesthetic Assessment

Date: ___________________________  
Sign: ___________________________

Anesthetist: ___________________
Unit No.: _______________________

Surgeon / Team: __________________
Data Planner: __________________

Planned Procedure: __________________
Other Name: _____________________
DOB / Sex: _______________________

General: ASA 1 2 3 4 5

Age: ______  Sex: ______  Weight: _______  Height: _______
BMI: _______  kg/m²

History of present illness:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Intercurrent illnesses:

☐ Nil

Allergies: Nil ☐

Medications:

Cgs ___________  Packys ___________  Puh ___________  g/d

Relevant Anaesthetic History:

☐ Nil

Anesthesia Mods: Nil ☐

Perioperative Management Plan:

Admission process explained: ☐

Take usual medications on DOS ☐ except:

☐ Perioperative Options Discussed: ☐

Perioperative Risks Explained:

Admission Status: ☐ Day Only  ☐ Day of Surgery Admission (+1night)

 signature: ___________________________

Extended Day Only  ☐ Full Admission

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

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# Pre-admission Examination & Evaluation

## Cardiovascular

- **BP:**
- **HR:**
- **JVP:**
- **Carotids:**
- **HS:**
- **Ankle oedema:**
- **Pulses:**

## Respiratory

- **SpO₂:**

## Airway & Teeth

- **Mallampati / Oat Score:**

## Neurological

<table>
<thead>
<tr>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power</td>
<td>15</td>
</tr>
<tr>
<td>UL</td>
<td>15</td>
</tr>
<tr>
<td>LL</td>
<td>15</td>
</tr>
<tr>
<td>Pupils</td>
<td></td>
</tr>
</tbody>
</table>

## Other

## Blood Results

- **BIOCHEM:**
- **HAEM:**
- **Other:**
# Appendix 5: Primary Care / GP Assessment Tool

## Primary Care Practitioners Supplementary History

*Please answer the following questions by ticking the appropriate response. Where necessary, provide additional details. If there are any queries, phone the clinical screener on [number].*

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of birth:</th>
</tr>
</thead>
</table>

1. Are the patient's answers to the Health Questionnaire complete and accurate?
   - Yes [ ]
   - No [ ]
   - I did not see a copy of the patient questionnaire [ ]

   *If appropriate, please complete the patient questionnaire or annotate corrections and send/fax a copy of your health summary to the Perioperative Service.*

2. Are there other specialists sharing the care of your patient? (Other than the one performing the procedure)
   - Specialty:
   - Name:
   - Practice location:
   - Phone Number:

3. Please tick below any recent (<12 months) reports or results that you have from:
   - If yes, please send any relevant reports or results to the Perioperative Service.
   - Haematology [ ]
   - ECG [ ]
   - Serum Chemistry [ ]
   - Echocardiography [ ]
   - Chest X-ray [ ]
   - Physician's letters [ ]
   - Other: [ ] Details

4. Please give details of any current medications not listed by the patient. If more space is required, please attach a complete list.
   - Medication
   - Dose
   - Frequency

5. What is the control or stability of major chronic medical problems (e.g., hypertension, diabetes)
   - Chronic condition
   - Duration (years)
   - Control / Stability
     - Well controlled [ ]
     - Poorly controlled [ ]

6. How would you describe your patient's mobility and general functional ability?
   - Fully independent [ ]
   - Generally independent [ ]
   - Generally dependent [ ]
   - Fully dependent [ ]

7. Is there anything (other than those chronic conditions) that may impact on the patient's perioperative care? Please list
   - No [ ]
   - Yes [ ]

---

<table>
<thead>
<tr>
<th>Practitioner Name:</th>
<th>Signature:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

*GP Practice Stamp*
### 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 2 weeks
- Changes to the medicines you take
- Injuries or scratches

---

### Preparing to come to hospital

<table>
<thead>
<tr>
<th>Need to know</th>
<th>Write here</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time to arrive at the Perioperative Unit</td>
<td></td>
</tr>
<tr>
<td>Time to stop eating</td>
<td></td>
</tr>
<tr>
<td>What you can drink and time to stop drinking</td>
<td></td>
</tr>
<tr>
<td>The medicines/tablets you should take on the day of your surgery with some water</td>
<td></td>
</tr>
<tr>
<td>If you have diabetes</td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td></td>
</tr>
<tr>
<td>Blood tests and x-rays</td>
<td></td>
</tr>
<tr>
<td>How long you are likely to stay in hospital</td>
<td></td>
</tr>
<tr>
<td>Hospital visitor times</td>
<td></td>
</tr>
<tr>
<td>What to bring</td>
<td></td>
</tr>
<tr>
<td>What to leave at home</td>
<td></td>
</tr>
</tbody>
</table>
Arriving at hospital
Car parking is available, however costs may be involved.
The entrance to the car park is at ______________ or ________________.
Once you have parked or arrived at the hospital entrance, follow the
directions below to where you need to check in.
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.

<table>
<thead>
<tr>
<th>What do I do about:</th>
<th>You should…</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain medicine</td>
<td>Follow the instructions on the packet: ____________</td>
</tr>
<tr>
<td>Wounds and dressing</td>
<td>Leave your dressing intact for ___ days. When you shower you should: ____________</td>
</tr>
</tbody>
</table>
| Activity            | Exercise: ____________
|                     | Lifting: ____________
|                     | Driving: ____________
|                     | Working: ____________ |
| Diet / Food you can eat | _______ diet. 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: Dr: _______ Date: _______ Time: _______ Place: _______ |
| If you have any questions, please ring: | ____________________ |
### Shared Outcomes Tool – for patient, family and carers

<table>
<thead>
<tr>
<th>Ideal outcome</th>
<th>Agreed outcome/s</th>
<th>Notes on outcome/s following surgery / procedure</th>
<th>Outcomes following surgery / procedure discussed with surgeon and anaesthetist</th>
<th>Further comments / notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeon / Proceduralist perspective: e.g. reduced knee pain</td>
<td>Surgeon &amp; patient:</td>
<td>i.e. What was the outcome?</td>
<td>Yes / No Provide details of discussion:</td>
<td>Any other notes on the surgery / procedure / patient journey [relating to outcomes]:</td>
</tr>
<tr>
<td>Patient perspective: e.g. walk and play golf without pain</td>
<td>Anaesthetist &amp; patient:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetist perspective:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This tool records the information and agreed outcomes discussed between you, your family/carer, surgeon/proceduralist and the anaesthetist.*
## Appendix 7: Patient Information Checklist

The following information may be included when the Perioperative Service team is providing written education and instructions for patients and their carers.

<table>
<thead>
<tr>
<th>Information for patients and their carers should include:</th>
<th>Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details of the operation to be performed</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Expected benefits of the surgery / procedure and risks involved.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Details of the anaesthetic – e.g. what is a general anaesthetic.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>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.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Overview of usual recovery for the patient’s procedure including:</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>• When the patient will usually eat and drink</td>
<td></td>
</tr>
<tr>
<td>• Mobilisation</td>
<td></td>
</tr>
<tr>
<td>• Return home</td>
<td></td>
</tr>
<tr>
<td>Degree of pain anticipated and how the pain is relieved, e.g. details of techniques such as patient controlled analgesia.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Approximate time off work needed.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>When will it be safe to resume normal activities e.g. driving.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>The perioperative screener’s contact details for the patient and/or carer to ring if:</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>• They cannot attend on the day of surgery</td>
<td></td>
</tr>
<tr>
<td>• There has been a significant change to their medical condition</td>
<td></td>
</tr>
<tr>
<td>• Their medication has changed</td>
<td></td>
</tr>
<tr>
<td>• They need advice.</td>
<td></td>
</tr>
<tr>
<td>What to bring on the day of admission.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>A hospital map, car parking (including costs) and/or other transport arrangements.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Hospital visiting times for relatives.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>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.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Where relevant, make the patient and/or carer aware of other services, including interpreter, Aboriginal Liaison Officers etc.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
<tr>
<td>Costs attached to the surgery / procedure and/or hospital stay.</td>
<td>Yes ☐  No ☐  N/A ☐</td>
</tr>
</tbody>
</table>
Appendix 8: Standardised Perioperative Pathway

Appendix 8 – Standardised Perioperative Pathway – 1/1

<table>
<thead>
<tr>
<th>Insert LHD/hospital name here</th>
<th>Surname:</th>
<th>MRN:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Given Name(s):</td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td>D.O.B:</td>
<td>M.O:</td>
</tr>
<tr>
<td></td>
<td>Address:</td>
<td>Location/ward:</td>
</tr>
</tbody>
</table>

Form completed by: ______________ Date: ______________

Planned Procedure: ____________________________

Emergency/Elective: ____________________________

Planned Care Pathway: ____________________________

Expected length of stay: ______________ Variances: ______________

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: ______________ Variances: ______________

Pre
Intra
Post

Anticipated level of care for patients post procedure: ______________ Variances: ______________

Day Surgery | EDO ward | Ward | HDU | ICU

Clinical handover from hospital to primary care: ______________ Variances: ______________

General Practitioner | Community Nursing | Family/Carer

Patient requirements for transfer to primary care: ______________ Variances: ______________

Transfer of care summary | Pain Relief | 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: ______________