

Clinical Guideline

Title: Pre-Anaesthetic Assessment Guideline for Country Health SA Local Health Network Hospitals

Procedure developed by: CHSALHN Pre-Anaesthesia Assessment Guideline

Development Working Group

Procedure Sponsor: CHSALHN, Chief Medical Advisor

Approved by: CHSALHN, Clinical Governance Committee on: 2 March 2016

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Summary This clinical guideline sets out the requirements for ensuring a safe, structured anaesthetic pathway for all CHSALHN clients undergoing planned ('elective') surgery at Country Health SA sites.

Policy reference This guideline supports the Elective Surgery Policy Framework and Associated Procedural Guidelines; Framework for Active Partnership with Consumers and the Community Policy Directive; Clinical Handover Policy Directive; Improving Access to SA Health Services and the Standards for the Management of the Obese Obstetric Woman in South Australia.

Keywords Guideline, CHSALHN, anaesthetic, anaesthesia, pre-anaesthetic, assessment, pre-anaesthetic consultation, PAC, BMI, anaesthetic co-morbidities, obstructive sleep apnoea, OSA, anaesthetic difficulty, opiate

Procedure history Is this a new clinical guideline? **Y**
Does this guideline amend or update an existing procedure? **N**
Does this procedure replace an existing procedure? **N**

Applies to This clinical guideline applies to CHSALHN surgical services providing services to both public and private patients

Objective File Number 2016-05257

Version control and change history

Version	Date	Amendment	Amended by:
1.0	2 March 2016	Original version	CHSALHN Pre-Anaesthesia Assessment Guideline Development Working Group

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CLINICAL GUIDELINE

Pre-Anaesthetic Assessment Guideline for Country Health SA Local Health Network Hospitals

1. Overview/Procedure Description

Appropriate pre-anaesthetic management forms a crucial component of patient care in the surgical setting. This Guideline outlines the principles which would be expected to ensure a safe, structured anaesthetic pathway for patients undergoing planned ('elective') surgery at Country Health SA sites.

The framework will follow the maxim of "CORRECT PATIENT, CORRECT FACILITY, CORRECT SURGERY" and supports the Elective Surgery Policy Framework and Associated Procedural Guidelines; Framework for Active Partnership with Consumers and the Community Policy Directive; Clinical Handover Policy Directive, and Improving Access to SA Health Services Policy Directive, and is aligned with WHO and ANZCA best practice guidelines

These principles represent a minimum requirement for pre-anaesthetic clinical practice in CHSALHN facilities.

2. Areas of Responsibility

2.1 CHSA Executive is responsible for endorsing the guideline, and for ensuring that it remains current. It is also responsible for ensuring that an implementation process with a whole-of-Country focus is undertaken alongside the release of the Guideline.

2.2 Directors of Nursing and Midwifery (DONM) /Executive Officers (EO) are responsible for ensuring that there are

- fail-safe systems and procedures/instructions are in place at their local site(s) to ensure the Guideline principles are fully implemented
- all the local procedures/instructions which relate to these guidelines are routinely followed
- the hospital can meet each patient's identified peri-operative requirements including the appropriate level of post-operative care

2.3 Theatre Administration Staff are responsible to ensure that all flow on aspects of each patient's needs (for example, equipment availability; patient referred back to surgeon for transfer to waiting list at another facility;) are met in a timely fashion

2.4 Surgeons and Anaesthetists are responsible for following the principles of this guideline and the associated site/region-specific procedures

3. Clinical Guideline Details

3.1. Patients' fitness for surgery and the associated anaesthesia is ultimately the responsibility of the surgeon and the anaesthetist who will undertake the procedure. It is recommended that all patients should undergo timely pre-anaesthetic screening prior to surgery as per ANZCA PS07 (2008), Sections 2.2 and 2.5.

3.2. When surgery is to be performed and there is an anaesthetic risk requiring a level of service greater than that which the presenting anaesthetist/anaesthetic

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service has the capacity to provide, alternatives—such as transfer to a service that can provide care, or movement of more experienced staff to the patient at the time of surgery—must be considered

3.3. Patient information:

It is recommended that patients receive a patient information leaflet/booklet outlining what to expect in relation to anaesthesia for surgery. It should be written in simple language and be provided to patients in a timely way. It would include information on, for example

- 3.3.1. What anaesthesia is;
- 3.3.2. The need for pre-anaesthesia screening;
- 3.3.3. Managing usual medications when having surgery;
- 3.3.4. What to expect on the day of surgery;
- 3.3.5. What to expect post-surgically.

3.4. Pre-anaesthetic Screening:

- 3.4.1. A pre-anaesthetic screening for each patient should be completed and vetted by an anaesthetist or suitably trained staff;
- 3.4.2. Completion and review of the pre-anaesthetic screening assessment should occur in a timely way,
- 3.4.3. Ideally before surgery is formally wait-listed / booked,
- 3.4.4. Usually within several weeks of the recommendation for surgery being made to the patient,
- 3.4.5. Immediately if the surgery is to be undertaken within two weeks of the surgical consult.

Timely completion and review of the screening assessment will:

- facilitate the patient's journey whether it be within the originally-planned facility or involves transferring the patient to a waiting list in another facility/LHN due to their anaesthetic complexity;
- enable early identification of patients requiring an early Pre-Anaesthetic Consultation with an anaesthetist so that appropriate management (e.g. equipment and staff resourcing) can be foreshadowed and pre-arranged;
- enable commencement of activities to improve/control a patient's comorbidities for example by identifying the need for assessment of newly identified condition(s) and/or the institution of program(s) to improve the status of known conditions (such as diabetes, asthma, sleep apnoea, COAD, anaemia) prior to the surgery.

3.5. Pre-Anaesthetic Consult (PAC)

Consideration must be given to the complexity of each case. For example, a person presenting with several identified 'low risk' factors might be more accurately assessed as being at 'moderate risk' due to the complexity of their general health.

Particular responses or combinations of responses to the pre-anaesthetic screening will therefore indicate the need for a Pre-Anaesthetic Consult (PAC) (telephone or face-to-face) and/or additional assessment(s). These are:

- a) Prior history of difficulty with anaesthesia such as difficulty with intubation and/or a reaction to anaesthetic;
- b) BMI >35 with comorbidities; or BMI >40* without comorbidities; for any surgery involving more than a local anaesthetic block;
- c) A history of sleep disordered breathing, including Central or Obstructive Sleep Apnoea or obesity related hypoventilation;
- d) Surgical complexity 3-5, (SC III-V per CSCF v2 descriptors; *Appendix 1*);
- e) Co-morbidities rated at medium to high on the Levels of Risk table (*Appendix 2*);
- f) Anticipated complex postoperative management including pain management.

None of these factors would result in an automatic refusal to proceed. Rather, they indicate the need for a full review of the patient's suitability for the required anaesthesia at the selected site.

***NB** *No birthing will be undertaken in a level 3 obstetric service for BMI>40. SA Health "Standards for the Management of the Obese Obstetric Woman in South Australia"*

3.6. Pre-admission review for anaesthesia.

Ideally, the anaesthetist will undertake a further review of the patient's situation prior to the day of surgery if the pre-anaesthetic screening or consultation was undertaken more than 3 months prior to booked surgery, as per ANZCA PS07, "a final assessment by the anaesthetist, in a timely manner, is considered mandatory."

This will enable follow-up of interventions taken for comorbidity optimisation as well as other potential changes to the patient's health status.

3.7. Risk Management.

- 3.7.1. Decision-making with regard to proceeding with anaesthesia is based on a risk-management and risk balancing rather than a risk aversion approach. That is, the individual risk of not undertaking the surgical procedure or of undertaking it at another location potentially without the necessary psycho-social support, will be balanced against the relative risk of proceeding with anaesthesia at the planned facility.
- 3.7.2. Anaesthetists should consider consulting anaesthetist colleagues on more complex and high risk cases.
- 3.7.3. When an anaesthetist and a patient agree to proceed with anaesthesia in a situation where risk balancing has been a significant aspect of the decision-making discussion, the rationale for proceeding should be clearly documented along with the explicit consent of the patient, acknowledging the additional risks and the risk balancing that has been agreed. The anaesthetist should also document the specific risk-limiting strategies which have been implemented peri-operatively.
- 3.7.4. The Anaesthetist should ensure that the plan and care requirements of each patient have been communicated to the care team in a timely manner. This would include making the nursing manager aware that a higher risk patient has been scheduled thus enabling rostering of suitably experienced theatre nursing staff.

3.8. Post-operative care

Responsibility for post-operative medical and nursing care, which is individualised for each patient's identified needs, should be clearly documented and communicated to the relevant doctor and Director of Nursing and Midwifery or nominee prior to commencement of surgery.

3.9. Late cancellation.

At all times patient safety is the primary concern. An anaesthetist and other surgical services clinical staff will be supported in cancelling a planned procedure on the appointed day when

- dictated by updated information about the patient's deteriorating condition and/or complexity of needs
- the post-operative follow-up is not reliably available
- the anaesthetist believes s/he does not have sufficient experience to proceed under the conditions applying on that day, including unexpected non-availability of needed resources (e.g. equipment or suitably experienced staff).

3.10. Resolution of differences

In the event of a difference of opinion (among clinicians or between clinicians and the relevant hospital's management), about whether a particular patient can undergo a planned procedure based on their anaesthetic risk, a CHSA-appointed Anaesthetic Specialist lead (a person with knowledge and experience in Country Health SA) will moderate the final decision.

4. Evaluation criteria

Compliance and impact to this guideline will be monitored via the following mechanisms:

- Audit of implementation of the guidelines by site;
- Relative rate of late cancellations due to insufficient pre-anaesthetic preparation (base line pre-implementation measure vs annual post-implementation measure);
- Relative rate of post-surgical complications (base line pre-implementation measure vs annual post-implementation measure);
- Patient length of wait for surgery – subject to data availability;
- Unanticipated admission to high dependency or transfer to higher level care (SLS data and deteriorating patient information)

5. References and Attached Documents

5.1. Attached Documents

Document Name
APPENDIX 1: Surgical Complexity Measures
APPENDIX 2: Levels of Risk
APPENDIX 3: Flow Chart: Best Practice pre-anaesthetic patient pathway for planned surgery at Country Health SA LHN sites

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5.2. References

Document Name
Clinical Services Capability Framework (CSCF): Anaesthetic Services v3.2, https://www.health.qld.gov.au/publications/clinical-practice/guidelines-procedures/service-delivery/cscf/cscf-anaesthetic.pdf or www.health.qld.gov.au Search term: CSCF anaesthetic services
Management of Obesity in Pregnancy, College Statement C-Obs 49, September 2013, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, www.ranzcog.edu.au/college-statements-guidelines.html
Peri-operative management of the obese surgical patient 2015, Anaesthesia 2015, 70, 859–876, http://onlinelibrary.wiley.com/doi/10.1111/anae.13101/full
Recommendations for the Pre-Anaesthesia Consultation, Australian and New Zealand College of Anaesthetists (ANZCA), 2008, ABN 82 055 042 852, http://www.anzca.edu.au/resources/professional-documents : Document PSO7
SA Health Clinical Handover Policy Directive
SA Health Elective Surgery Policy Framework and Associated Procedural Guidelines
SA Health Framework for Active Partnership with Consumers and the Community Policy Directive
SA Health Improving Access to SA Health Services Policy Directive
SA Health Paediatric Clinical Guidelines: Women with high body mass index
SA Health Standards for the Management of the Obese Obstetric Woman in SA Policy Directive
SA Health Standards for the management of Obese Obstetric Woman - Patient Information Brochure
StopBang Questionnaire, Toronto Western Hospital, University Health Network, University of Toronto, 2013, http://www.stopbang.ca/
WHO Guidelines for Safe Surgery, 2009
Zafar Ahmad Usmani, Ching Li Chai-Coetzer, Nick A Antic, R Doug McEvoy; BMJ, April 2014, <i>Obstructive sleep apnoea in adults</i> ;, http://pmj.bmj.com Search for: Obstructive sleep apnoea in adults

6. Consultation

Version	Consultation
1.0	CHSALHN Pre-Anaesthesia Assessment Guideline Development Working Group, CHSALHN Peri-operative Managers Committee, CHSALHN Clinical Governance, CHSALHN Director of Surgical Services, CHSALHN Director of Medical Services, Rural Doctors Association South Australia, Australia and New Zealand College of Anaesthesia, Australian Society Anaesthetist

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APPENDIX 1: Surgical Complexity Measures

Complexity	Characteristics
Surgical complexity I (SCI) (e.g. local anaesthetic for removal of lesions)	<p>This level of surgical complexity:</p> <ul style="list-style-type: none"> • is an ambulatory/office surgery procedure • requires local anaesthetic, but not sedation • requires a procedure room, aseptic technique and sterile instruments, but not an operating theatre • requires access to resuscitation equipment (including oxygen) and a means of delivery • requires an area where patients can sit, but not a recovery room • generally does not require post-operative stay or treatment • does not require support services other than suture removal or a post-operative check.
Surgical complexity II (SCII) (e.g. local anaesthetic and/or sedation for excision of lesions)	<p>This level of surgical complexity:</p> <ul style="list-style-type: none"> • is usually an ambulatory, day-stay or emergency department procedure • requires local anaesthesia or peripheral nerve block and possibly some level of sedation, but not general anaesthesia • requires at least one operating room or procedure room, and a separate recovery area.
Surgical complexity III (SCIII) (e.g. general anaesthesia for inguinal hernia)	<p>This level of surgical complexity:</p> <ul style="list-style-type: none"> • usually requires general anaesthesia and/or a regional, epidural or spinal block • requires at least one operating room and a separate recovery room • may be a day-stay/overnight case or extended stay case • may have access to close observation care area/s.
Surgical complexity IV (SCIV) (e.g. general anaesthesia for abdominal surgery i.e. laparotomy)	<p>This level of surgical complexity:</p> <ul style="list-style-type: none"> • involves major surgical procedures with low to medium anaesthetic risk usually requires general anaesthesia and/or a regional, epidural or spinal block • has potential for perioperative complications • has close observation care area/s • has access to intensive care services • may have capacity to provide emergency procedures.
Surgical complexity V (SCV) (e.g. general anaesthesia for any major or complex surgery)	<p>This level of surgical complexity:</p> <ul style="list-style-type: none"> • includes major surgical procedures with high anaesthetic risk • includes surgery and anaesthetic risk with the highest potential for intra- and post-operative complications • provides the most complex surgical services • requires specialist clinical staff, equipment and infrastructure • has on-site intensive care services • may have extensive support services available.

Note to table: Developed by the Qld Department of Health CSCF Surgical, Perioperative and Anaesthetic Services Advisory Groups (acknowledging the gap in surgical descriptors between intermediate and complex within the CSCF version 2.0, 2005) Clinical Services Capability Framework version 3.1 Anaesthetic Services, Qld Health Page 15 of 16

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APPENDIX 2: Levels of Risk

Rating	Description	Level of risk
ASA 1	A normal, healthy patient.	LOW
ASA 2	A patient with mild systemic disease and no functional limitations	LOW
ASA 3	A patient with moderate to severe systemic disease that results in some functional limitation.	MEDIUM
ASA 4	A patient with severe systemic disease that is a constant threat to life and functionally incapacitating.	HIGH
ASA 5	A moribund patient who is not expected to survive 24 hours with or without surgery.	HIGH
ASA 6	A declared brain-dead patient whose organs are being removed for donor purposes.	NA
E	A patient requiring an emergency procedure.	

Adapted from:

- Physical classification system of ASA1 Manual for Anesthesia Department Organization and Management 2003–04 (ASA1, 520N Northwest Highway, Park Ridge, Illinois 60068-2573);
- Physical classification system of The American Society of Anesthesiologists' Manual for Anesthesia Department Organization and Management 2003–04
- Australian;and New Zealand College of Anaesthetists documents Anaesthetic services CSCF v3.2

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APPENDIX THREE: FLOWCHART: Best Practice pre-anaesthetic patient pathway for planned surgery at Country Health SA LHN sites

