Pre operative assessment

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Overview

- Organisational issues and models for pre-operative assessment pathways
- Key criteria for selection
- Measuring the effectiveness of the pre-operative assessment process
When and where should assessment take place?

• Staged assessment process
  – Primary care “Fit to refer” assessment
    • BP
    • Chronic disease control
    • BMI
    • Smoking status
  – OPA “Fit to list” assessment
    • Operation explained
  – POA “Fit and ready to go”
    • Formal assessment and investigations
Timing of assessments

• As early as possible but consider
  • MRSA screening
  • Change in health while waiting
  • Timing investigations
  • Recall of patient instructions

• Telephone review closer to date

• Text reminders
Location of assessment—pros and cons

- **Primary care**
  - Convenient for patient but difficult to provide efficient and comprehensive service

- **Out-patients or drop-in service**
  - Convenient for some patients but less efficient

- **Pre assessment clinic**
  - Less convenient but comprehensive back-up

- **Home eg Telephone assessment**
  - Convenient but may need to go elsewhere for any tests etc
Tailor services

- Urgency of surgery
- Severity of surgery
- Patients' fitness and need for additional input
  - Investigations
  - Anaesthetic review
Types of Pre-assessment teams

• Separate day surgery and in-patient teams common historically

• Pros-
  • greater expertise in day surgery assessment
  • More accurate patient information

• Cons
  • More chance of delays for patients
  • May reduce potential day case numbers
Criteria for selection

• Assume day surgery management for all appropriate procedures i.e. consider criteria for exclusion
• Social circumstances
• Medical problems
Social circumstances

• Need for carer for 24 hours after surgery
  – Depends on surgery and usual circumstances
    • Give patient accurate information about why a carer may be needed
    • May not be needed actually on site for 24 hours or maybe needed longer than 24 hours

• Journey time less than an hour
  – Depends on nature of surgery
  – Potential for return to hospital with complication
Medical conditions

• Consider how patient will benefit from staying in hospital
  – Will it be safer?
  – Will it be more comfortable?
  – Is a GA necessary?

• Absolute contraindications few
  – Neuromuscular disorders that deteriorate after a GA AND require a GA
Relative contra-indications

- Obstructive sleep apnoea
  - Is a GA essential?
  - Will airway be any more obstructed after anaesthesia and surgery?
  - Will sedating drugs be used?
  - Can patient use own CPAP at home safely?
Diabetes

• Diabetics best managed as day case
  • Retain control
  • Minimise fasting

• BUT 25% day units in 2012 did not manage Type 1 diabetics as day cases

  » ¹National guidelines- Management of adults with Diabetes undergoing surgery 2011
Management of adults with diabetes undergoing surgery and elective procedures: improving standards
Obesity

• BMI should not be used to exclude patients from day surgery option
  • RCA and Asscn Anaesthetists guidance 2011
• BUT high BMI patients still not popular in day surgery
  – disruption to rapid turnover
  – anxiety about peri-op problems and rapid availability of assistance
• Minimise problems
  • anaesthetic review at POA,
  • extra time on list
  • risk assessment for isolated sites
Old and frail with home support

- Hospital stay is high risk
  - Post-op confusion
  - Hospital Acquired infections
  - Home support is withdrawn
- Day surgery with minimal intervention is best
Un-controlled co-morbidities

• Elective surgery should not be offered until patients condition is improved as far as possible
• Day surgery option may then be appropriate
• In-patient stay is not an alternative to correct patient preparation
Effective pre-operative assessment

• Minimises delays for planned surgery
  • Medical reasons

• Minimises cancellations on the day
  • Medical reasons
  • Patient DNA
  • Operation not needed or wanted
  • Equipment, staff, capacity or other issues
Elective surgical pathway

Patient with surgical problem → Surgical OPA → Pre op assessment → Surgery → recovery
Common problems with current pathway

1. Patient with surgical problem
2. Surgical OPA
3. POA
4. Surgery
5. Recovery

British Association of Day Surgery  www.bads.co.uk
How common are cancellations for medical problems?

- Survey by NHS Midlands and East in 2013
- 23 trusts assessing 16,000 patients over 4 weeks
- 2% of patients (320) had planned surgery delayed or cancelled due to medical problem detected at POA

  • Improving the pathway for planned care. A Pre-Operative Assessment Study. Feb 2013. NHS Midlands and East
Common medical reasons for delays

- Blood pressure
- Poorly controlled diabetes
- AF
- Heart murmurs
- On anti-coagulants, anti-platelet drugs
- Need to lose weight
- Need to stop smoking
Why do patients DNA or cancel?

- Don’t receive information
- Short notice for date
  - Arrangements for family/work/holidays
- Unaware of duration and arrangements for recovery
- Don’t want or need surgery anymore
What can we do to streamline pathway?

- Timing of pre-op assessment
  - Start early and tailor assessment to patient need
- Offer dates for surgery as early as possible in discussion with patient
- Ensure surgical lists are realistic and planned with surgeon
- Review short notice cancellation reasons to assess effective pathways
Summary

- POA pathway should be tailored for patient and start in primary care
- Day case management should be default for appropriate procedures
- Review pathway to minimise hospital visits and identify delays
- Monitor cancelled operations to measure success
BADS handbooks

Further reading

www.bads.co.uk