

**SECTION 1****GENERAL GUIDELINES**

<b>POLICY CM 1.3</b>	<b>PATIENT SELECTION PROTOCOL</b>
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**AIM/OUTCOME:** To provide a patient focused quality healthcare service through appropriate patient admission protocols. The facility strives to provide a safe and risk free patient episode of care and ensures appropriate patients are admitted.

**POLICY APPLIES TO:** Accredited Medical Practitioners  
Clinical Nursing Staff  
Administration Staff

**POLICY:**

**Patients are referred to the hospital by their Accredited Medical Practitioner (AMP) and must be a suitable candidate for day surgery.**

**Patients should be essentially healthy people with good home support available.**

**PMA facilities are risk-averse in regards to all elective and time sensitive surgery. The Board and MAAC endorse a conservative approach to patient safety – surgery should be cancelled and re-scheduled should patients be identified as not suitable for theatre due to clinical and social reasons.**

**All patient admission forms are all reviewed by a Registered Nurse. Permission for admission will depend upon suitably trained staff and equipment being available to meet the needs of the patient. Patients that don't meet the patient selection protocol are referred to an alternate facility in consultation with the patient and their AMP.**

**Chatswood Private Hospital is licensed to provide 23 hour care to patients who require extended observation and care following surgery.**

**This policy covers all PMA Day Hospitals. Specific and extra requirements relevant to the respective facility are listed within the policy.**

**The Patient Selection Protocol is to be reviewed by the Medical Advisory & Audit Committee (MAAC) and Quality Review Committee (QRC) at 12 monthly intervals, or as required.**

**PROTOCOL FOR PATIENT SELECTION:**

- A responsible adult is available to transport the patient and must accompany the patient home in a suitable vehicle. A train, tram, or bus is not suitable. For some patients it may be important to have an adult escort as well as the vehicle driver. A responsible person should be available to stay at least overnight following discharge from the facility. This person must be physically and mentally able to make decisions for the patient's welfare when necessary. (See Section: *Unaccompanied Discharge*)
- Parents, carers or guardians are to accompany children. Admission to be planned carefully to avoid causing distress to the child and family. The needs of children and young people are very different to those of adults.

- Surgery will not proceed on any patient if the Surgeon or Anaesthetist feels it will endanger the patient's health. All Surgeons and Anaesthetists are responsible for their patients' pre-op assessment.
- For a patient that has experienced a recent COVID-19, the MAAC have advised that elective surgery following COVID 19 infections should be delayed for 8 weeks and then based on a clinical risk assessment.

*Following a request from the MAAC, the CEC has sought the advice of the NSW Agency for Clinical Innovation (ACI) and the NSW Health Surgical CoP. Within the ACI documentation there is a recommendation that surgery is deferred for at least 6 weeks after recovery from confirmed COVID-19 infection. Information to date suggests surgery either during active infection or in the few weeks after COVID-19 is associated with both higher morbidity and mortality, possibly due to an ongoing pro-inflammatory state. It is unclear with this risk extends to operations conducted under local anaesthetic only. However, it would be prudent for non-urgent operations be deferred for a minimum period of 6 weeks after recovery from acute symptoms from COVID-19.*

*The current conditional recommendation from the Australian National COVID-19 clinical evidence taskforce <https://app.magicapp.org/#/guideline/L4Q5An/section/ERoNXj> is "do not routinely perform elective surgery within eight weeks of recovery from acute illness, following a diagnosis of SARS-CoV-2 infection, unless outweighed by the risk of deferring surgery, such as disease progression or clinical priority." Please refer to this website for further recommendations and updates.*

If clinical need is pressing, surgery may be done earlier at 6 weeks (IV sedation/LA) and not scheduled for GA and the patient was asymptomatic – all subject to anaesthetist/surgical review.

- Patients have pre-anaesthetic consult either in a consult room or day ward area as specified in the ANZCA guidelines PS7 'Recommendations for the Pre-Anaesthetic Consultation' and meet the documented American Society of Anesthesiologists Physical Status Classification (ASA) Level of 1, 2, 3 or stable 4. **ASA 4 Patients may undergo regional or IV sedation only (No Planned Elective GA's).**

SCORE	DESCRIPTION
ASA 1	A normal healthy patient
ASA 2	A patient with mild systemic disease
ASA 3	A patient with severe disease that limits activity but is not incapacitating
ASA 4	A patient with severe life threatening systemic disorder which may not be corrected by the operation
ASA 5	A moribund patient with little chance of survival

- Patients with a pre-existing condition that the hospital is not equipped to manage. (E.g. acute psychotic illnesses) are not suitable for treatment in the facility.
- Patients that are known to be susceptible to be or could be susceptible to Malignant Hyperthermia due to a positive in vitro contracture test, a suspected intraoperative episode or a family history of MH are not suitable for admission unless alternate anaesthesia arrangement are instigated (Machine preparation, no volatile Anaesthetic agents or Suxmethoniim). Patients who have been tested and found to be negative can undergo a normal anaesthetic i.e. do not require alternative anaesthetic techniques.
- Weight limit of 120 kg or having dimensions that are not accommodated by standard day procedure equipment – further assessment to be made by Chief Executive Officer (CEO), Hospital Director or Clinical Manager/Director of Nursing (CM/DON), Anaesthetist and Surgeon if patient is in good health and has sufficient strength to move independently. This is

to ensure we can provide a safe environment for both patients and the staff providing their care. Refer to policy CM 1.15 '*Bariatric Management Plan*'.

- Patients with mobility problems must be able to be transferred independently to the facilities' procedure bed or with the assistance of a carer. The facility has a no lift policy and has no provision for mechanical assistance of patients. (*See Section: People with Disabilities*).
- All patients will complete the necessary pre-admission patient documentation. These include:
  1. MR2: Patient Admission Form,
  2. MR2A: Pre-Admission & Medical Assessment Form,
  3. MR3: Recommendation for Admission,
  4. MR3A: Consent to Surgical Treatment – specific cataract procedures form and generic form for all other procedures
- Patients requiring services for which their AMP is not credentialed or it is not within their scope of practise will not be admitted. Refer to policy L&M 2.1 '*Credentialing and Clinical Privileges*'
- Patients with funding issues that are not resolved prior to admission will not be admitted. This would include:
  1. Workers Compensation patients without approval,
  2. DVA white cardholders without approval,
  3. Uninsured patients who are not electing to self-fund their admission to hospital.
- Patients who have shown non-compliance with the "Patients' Right and Responsibilities" will not be readmitted for subsequent treatment without the approval of the CM/DON. Refer to policy CM1.7 "*Patients' Right and Responsibilities*"

#### **CHATSWOOD PRIVATE HOSPITAL SPECIFIC**

- **The Chatswood Private Hospital Medical Advisory & Audit Committee does not endorse the admission of children under the age of 3 years for Tonsillectomy procedures**
- **Patients under two years of age or under 10kg with diagnosed sleep apnoea (as per sleep studies) are not to be admitted to CPH**

#### **UNACCOMPANIED DISCHARGE**

- Should patients' present unaccompanied, despite our best efforts, the following risk management and assessment policies will apply:
- ***All General Anaesthetic (GA) patients who do not have suitable discharge arrangements will be cancelled prior to the procedure. All GA patients must have a suitable escort to take them home and a carer at home overnight.***
- *Ophthalmic patients (Local, IV Sedation, and regional blocks) who do not have an escort &/or carer are advised that they are going outside the recommended guidelines. Every attempt should be made with the patient to arrange appropriate cover.*
- *If identified upon presentation to the facility during their admission that the patient is unaccompanied, the Anaesthetist and Surgeon are immediately informed. A risk assessment process is conducted by the Anaesthetist and Surgeon to proceed with surgery, or cancel and reschedule.*
- *If a decision is made to proceed with surgery, the Anaesthetist, in conjunction with the surgeon may be able to titrate the level of anaesthesia according to clinical need. Overnight admissions may be arranged for those unaccompanied patients requiring care and assistance post-operatively.*

- Those patient's staying overnight by themselves after surgery are encouraged to have a neighbour, community or a nursing agency carer to call and check on their welfare. Patients must complete the "Release of Facility's Responsibility for Discharge" statement on MR 9 "Variance Record" form in the patient clinical record prior to the procedure where possible.
- It is recognised that some patients will not have access to a carer and the decision to proceed with surgery should be made in consultation with the Surgeon & Anaesthetist. It is also recognised that despite information in the Patient Information Booklet, admission questionnaire and questioning during the pre-op call and nursing admission that some patients will not disclose their unaccompanied status until only during the discharge process.
- Refer to policy CM1.12.1 'Home Alone & Travel Alone Protocol'.

### *PEOPLE WITH DISABILITIES*

- Disabilities may include physical, sensory, developmental, psychiatric, age related.
- Pre-admission planning must include anticipating any additional disability support requirements that are likely to be necessary during hospitalisation and the communication of this information to relevant staff. It is essential that the role and expectation of carers and disability support workers are clarified at this time.
- The facilities' Pre Admission Risk Screening process will identify & address people's special needs during patient assessment.
- Transportation, mobility requirements and physical support needs including appropriate lifting and positioning are taken into account. Physical disability access to the facility must be considered and a wheelchair is available.
- Discharge planning for patients with disabilities commences prior to admission. Family and/or Carers are included when necessary in patient discharge planning.

### **OVERNIGHT CARE/ CHATSWOOD PRIVATE HOSPITAL SPECIFIC**

- Patients who require overnight care are to be identified in at the time of booking the procedure. This is to be documented on the Recommendation of Admission and should include the reason for the admission.
- The booking will be confirmed with the surgeons rooms by the Director of Nursing/Clinical Manager two weeks prior to the procedure to ensure the efficient and effective utilisation of the facility
- To meet the requirements of the 23 hour licence, all patients must be discharged by 8am on the day following surgery.
- All medications are to be written up on the patient's medication chart for administration during the admission.
- All surgeons whose patients are admitted overnight will need to be contactable by phone for the duration of the admission in case the patient requires additional medication or care. This requirement may be delegated to the anaesthetist if they are agreeable.

### **PERFORMANCE INDICATORS:**

This policy is linked to Clinical Management: Deteriorating Patient / Adverse Event and Cancellation after arrival entries on the Risk Register (Policy L&M 3.6.1) and are audited 6 monthly

1. ACHS Day Surgery Clinical Indicators: Cancellation after arrival, Unplanned Transfer, Delay in Discharge, Patient Adverse Events (Unintended harm) during care delivery and No Escort.
2. ACHS Anaesthetic Clinical Indicators: Unplanned ICU Admission Post op within 24 hours

**REFERENCES:**

1. Australian Day Surgery Nurses Association ‘Best Practice Guidelines for Ambulatory Surgery & Procedures’ 2013
2. NSW Ministry of Health IB2015\_31 ‘Disability- People with a disability: Responding to needs during Hospitalisation,’
3. ANZCA PS7 ‘Guidelines on Pre-Anaesthesia Consultation & Patient Preparation - 2017’
4. ANZCA PS15 ‘Guidelines for the Perioperative Care of Patients Selected for Day Care Surgery – 2018’
5. Australian Charter of Healthcare Rights
6. The International Association of Ambulatory Surgery ‘Day Surgery Development and Practice’ 2006 Edition
7. ‘Day Surgery in Australia – Report and Recommendations of the Australian Day Surgery Council of Royal College of Surgeons, Australian & New Zealand College of Anaesthetists and The Australian Society of Anaesthetists’ 2004 Revised Edition
8. Malignant Hyperthermia Australia & New Zealand (MHANZ) Resource Kit (2018) [www.anaesthesia.mh.org.au](http://www.anaesthesia.mh.org.au)
9. <https://app.magicapp.org/#/guideline/L4Q5An/section/ERoNXj>

RATIFIED BY:	Quality Review Committee	Medical Advisory and Audit Committee	Board
DATE:	October 2021	November 2021	November 2021
REVIEW DATE:	October 2022		
PREVIOUS REVIEW:	2009, 2011, 2013, 2016, 2017, 2018, 05/2019, 11/19,2020,2021		

DATE	POLICY CHANGES
January 2022	<ul style="list-style-type: none"> <li>• Addition restriction elective surgery following COVID-19 infection with reference to guidelines based on Clinical Innovation (ACI) and the NSW Health Surgical CoP. Endorsed MACC January 2022</li> </ul>
November 2021	<ul style="list-style-type: none"> <li>• Review at Strategic Planning Day October 2021 – Nil changes</li> </ul>
November 2020	<ul style="list-style-type: none"> <li>• Revised wording patient Malignant Hyperthermia admission criteria</li> </ul>
October 2020	<ul style="list-style-type: none"> <li>• Updated CPH discharge time for overnight patients to 8am.</li> </ul>
November 2019	<ul style="list-style-type: none"> <li>• Review Strategic Planning Day with nil changes required.</li> </ul>
May 2019	<ul style="list-style-type: none"> <li>• Addition of references to ANZCA Guidelines on home alone and travel alone with strengthening of risk assessment process for those patients who present, despite best efforts, unaccompanied.</li> </ul>
November 2018	<ul style="list-style-type: none"> <li>• Addition of risk assessment for children less than 12 months.</li> </ul>
October 2018	<ul style="list-style-type: none"> <li>• Added CPH specific paediatric sleep apnoea requirements</li> </ul>
March 2018	<ul style="list-style-type: none"> <li>• Addition of Malignant Hyperthermia references</li> </ul>
November 2017	<ul style="list-style-type: none"> <li>• Review at Strategic Planning Day November 2017 – Nil changes.</li> </ul>
September 2017	<ul style="list-style-type: none"> <li>• Updated with MDS and COFFS facility</li> <li>• Updated MDS and COFFS Specific details for Patient Selection Protocol</li> <li>• Updates endorsed by Coffs MAAC and Board on 29 September 2017</li> </ul>
December 2016	<ul style="list-style-type: none"> <li>• ASA Admission criteria revised by MAAC with changes</li> <li>• CPH Specific selection criteria specified more clearly</li> <li>• Also amalgamated the different facilities approved procedures into one overall PMA approved procedures policy with specific references to</li> </ul>

	individual facilities.
October 2015	<ul style="list-style-type: none"> <li>• Updated for ENT patients re carer expectations and relevant documentation</li> <li>• Tonsillectomy age range exclusion</li> <li>• Overnight care requirements</li> <li>• CPH details</li> </ul>
November 14	<ul style="list-style-type: none"> <li>• No Changes required</li> </ul>
November 2013	<ul style="list-style-type: none"> <li>• Updated terminology re from VMO to CMP and MAC to MAAC Updated References – dates and documents</li> <li>• Performance Indicators updated and linked to Risk Register</li> <li>• Updated the linked policies and references</li> <li>• Reviewed and reworded section relating to funding issues</li> </ul>