SECTION 1 GENERAL GUIDELINES

POLICY CM 1.3	PATIENT SELECTION PROTOCOL

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 <u>must</u> accompany the patient home in a suitable vehicle. A train, tram, or bus is not suitable. For some patients it <u>may</u> be important to have an adult escort as well as the vehicle driver. A responsible person <u>should</u> 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.

COVID-19 STANDARD OPERATING PROCEDURE TIMING OF ELECTIVE SURGERY

For a patient that has experienced a recent positive COVID-19 infection, the MAAC have advised that **elective surgery following COVID 19 infections should be delayed for 4-10 weeks based on clinical risk assessment and the current evidence below**:

Following a request from the MAAC, the Clinical Excellence Commission 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.

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.

- ***ADULT POST COVID-19 INFECTION RECOMMENDATION***

With the recent increase in cases thought to be due to the Omicron strain and no definitive guidelines from NSW Health, the **MACC have advised to adopt a more conservative approach based on Royal North Shore Hospital (RNSH) Division of Surgery and Anaesthetics recommendation**. Recognising that most of this evidence is based on the Delta variant, and that most cases of Omicron involve milder disease and almost certainly less preoperative risk it is reasonable to stratify the delay to scheduled surgery based on the severity of the COVID disease that patient experiences and other underlying risk.

RNSH guidelines are a three stage adaption of the four stage US guidelines mentioned in the ACI website.

i) Avoid surgery for 4 weeks in patients who have had asymptomatic disease or mild non-respiratory symptoms
ii) Avoid surgery for 8 weeks in patients who have had moderate to severe symptoms or have been hospitalised
iii) Avoid surgery for 10 weeks in patients who were admitted to ICU or who have underlying immunocompromised/diabetic/frailty

Day zero is the day of returning a positive PCR or RAT or if no test was done and a presumptive diagnosis was made, from the first day of symptoms.

These guidelines only apply to elective surgery.

For urgent Category 1 surgery (e.g. retinal detachment), where the risk of surgery and disease progression is outweighed by the risk of deferring surgery, the minimum limit will be 14 days as long as the patient is asymptomatic and has been medically cleared and made aware of the increased risk.

*Essentially risk of morbidity and mortality remains elevated for up to 8 weeks post COVID-19 infection.

- **PAEDIATRIC POST COVID-19 INFECTION RECOMMENDATION**

With the Paediatric cohort of patients, the MACC have adopted the recommendation from 'The Sydney Children's Hospital Network '(published 7th February 2022).

Elective surgery:*

- Patients who were asymptomatic with their COVID-19 diagnosis: postpone elective surgery for 2 weeks.
- Patients who had mild symptoms with their COVID-19 illness but did not require hospital admission: postpone elective surgery > 4 weeks.
- Patients who required hospital admission to manage their COVID-19 illness: postpone elective surgery > 7 weeks.

Urgent surgery:

An urgent procedure should not be delayed

- Consider the risks and benefits for each case an 'urgent procedure' refers to any scenario where a delay for the patient is likely to lead to a worse health outcome. The risks to the patient of delaying the procedure may outweigh the risks related to anaesthesia/procedure after recent COVID-19 infection.

- If possible, a 2 week window between COVID-19 symptoms resolving and the procedure may decrease the risk of perioperative respiratory complications.

**Note: the 2 week/4 week/7 week time periods are from the day of the positive COVID test.*

<u>A Note on Infectivity</u>

Once patients no longer require isolation, there is no ongoing concern of risk of transmission of COVID-19 when the patient presents for subsequent elective surgery.

Specific scenarios where additional specialty input may be required:

- Consult Infections Diseases for patients with specific Infectious Diseases such as patients with a compromised immune system
- Consult Haematology for patients who required anticoagulation during their COVID-19 illness. See *Thromboprophylaxis protocol for children with COVID-19 infection and MIS-C* for more information.

Perioperative PCR/Rapid antigen testing is not recommended within 4 weeks of COVID-19 infection. **Patients >4 weeks should be screened as usual**.

Key Summary Points

- There is very limited paediatric data to guide the approach to scheduling planned surgery after COVID-19 infection.
- Compared with adults, the rate of peri-anaesthetic complications appears likely to be lower.
- The small amount of evidence available suggests that postoperative pulmonary complications probably occur at a similar rate to paediatric patients with a recent URTI. One study suggests the rate of complications may be similar in those who have recently had symptomatic infection vs asymptomatic infection.
- In the paediatric population, delays to planned surgery should be considered against any potential risks to patient outcomes related to the indication for surgery. This includes the risk of changes in trajectory of development outcomes or key functional differences in outcome, not just mortality or morbidity.

The MACC will continue to monitor SARS-CoV-2 guidelines and will update accordingly.

- 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 Suxmethonuim). 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 in 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*
9. *https://app.magicapp.org/#/guideline/L4Q5An/section/ERoNXj*
10. https://aci.health.nsw.gov.au/covid-19/critical-intelligence-unit/living-evidence-surgery

11. RNSH: email from Dr Adam Rehak to the COVID lead on 24 January 2022
12. El-Boghdadly, K. et al. SARS-CoV-2 infection, COVID-19 and timing of elective surgery. Anaesthesia 76, 940–946 (2021).
13. Deng, J. Z. et al. The Risk of Postoperative Complications After Major Elective Surgery in Active or Resolved COVID-19 in the United States. Ann Surg 275, 242–246 (2022).
14. Cronin, J. A. et al. Anesthetic outcomes in pediatric patients with COVID-19: A matched cohort study. Pediatr Anesth 31, 733–735 (2021).
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18. Okonkwo, I. N. C. et al. The safety of paediatric surgery between COVID-19 surges: an observational study. Anaesthesia 75;1605-1613 10.1111/anae.15264 (2020).
19. Royal College of Pediatrics and Child Health. National guidance for the recovery of elective surgery in children. Accessed 4 February, 2022.
20. Howard-Jones, A. R. et al. COVID-19 in children. II: Pathogenesis, disease spectrum and management. J Paediatr Child H 58, 10.1111/jpc.15811 (2021).
21. COVID-19 Critical Intelligence Unit: Surgery post COVID-19 Feb 2022

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, 2022		

DATE	POLICY CHANGES
11 February 2022	• Separated Adult & Paediatric COVID-19 Timing of Elective surgery • Addition Paediatric COVID-19 Elective surgery guidelines • Addition 'The Sydney Children's Hospital network Guidelines' references • Addition 'COVID-19 Critical Intelligence Unit: Surgery post COVID-19', Feb 2022
27 January 2022	• MACC advised to Modify Time frames to elective surgery based on RNSH Division of Surgery and Anaesthetics guidelines
January 2022	• 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
November 2021	• Review at Strategic Planning Day October 2021 – Nil changes
November 2020	• Revised wording patient Malignant Hyperthermia admission criteria
October 2020	• Updated CPH discharge time for overnight patients to 8am.
November 2019	• Review Strategic Planning Day with nil changes required.
May 2019	• 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.
November 2018	• Addition of risk assessment for children less than 12 months.
October 2018	• Added CPH specific paediatric sleep apnoea requirements

March 2018	• Addition of Malignant Hyperthermia references
November 2017	• Review at Strategic Planning Day November 2017 – Nil changes.
September 2017	• Updated with MDS and COFFS facility • Updated MDS and COFFS Specific details for Patient Selection Protocol • Updates endorsed by Coffs MAAC and Board on 29 September 2017
December 2016	• ASA Admission criteria revised by MAAC with changes • CPH Specific selection criteria specified more clearly • Also amalgamated the different facilities approved procedures into one overall PMA approved procedures policy with specific references to individual facilities.
October 2015	• Updated for ENT patients re carer expectations and relevant documentation • Tonsillectomy age range exclusion • Overnight care requirements • CPH details
November 14	• No Changes required
November 2013	• Updated terminology re from VMO to CMP and MAC to MAAC Updated References – dates and documents • Performance Indicators updated and linked to Risk Register • Updated the linked policies and references • Reviewed and reworded section relating to funding issues