PG15(POM) Guideline for the perioperative care of patients selected for day stay procedures 2018

Short title: Day stay patients

1. Purpose

This guideline is intended to assist practitioners and healthcare facilities in the perioperative care of patients presenting for day stay procedures (DSP).

2. Scope

The guideline is intended to apply:

- in all healthcare facilities that provide procedural/diagnostic services where patients are discharged on the same day as having received anaesthesia.
- to all patients being discharged within 24 hours of a procedure whether this be in a standalone day procedure facility or an inpatient facility.
- to all anaesthetists and other medical practitioners who provide anaesthesia services, with the exception of sedation[1], to patients in such facilities.

PG09(G) Guideline on procedural sedation applies whenever parenteral sedation is to be used.

Definitions[2]:

Day Stay Procedures (DSP) in this document refer to any procedure where patients are discharged on the same day, or within 24 hours of their procedure. DSP encompasses terms such as “Day Surgery”, “Day Stay Surgery”, “Day Care Surgery”, “Ambulatory Surgery”, “Same Day Discharge”, as well as procedures performed on an outpatient basis.

Day Surgery (also called “Ambulatory Surgery”) refers strictly to patients admitted and discharged on the same day. “Outpatient” procedures have the same aim.

Anaesthesia includes general anaesthesia, regional anaesthesia/analgesia and sedation.

Healthcare facility refers to hospitals, clinics and office-based facilities where procedures are performed with concurrent administration of sedative medications (including opioids), general or neuraxial anaesthesia, or local anaesthesia (other than small volumes delivered by the subcutaneous or mucocutaneous route). The delivery of anaesthesia services at such facilities must comply with the approved licensing of the facility to ensure safe delivery of patient care (refer section 9 below).

3. Background

The ultimate aim of facilities performing DSP is to discharge their patients on the same day as their admission ideally back to their normal place of residence. Enhanced outcomes are dependent on careful patient selection combined with optimized anaesthesia for any given procedure in an appropriately resourced facility.

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[1] Refer to PG09(G) Guideline on procedural sedation
[2] Refer ANZCA Document Framework Policy Appendix 2: Glossary of terms available here.

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As an underlying principle, an appreciation of patient values should be considered when formulating any clinical decisions, reflecting respect for and responsiveness to individual patient preferences, needs and values.

The growing demand for procedures to be performed on a day stay basis has seen the proliferation of facilities providing a wide range of procedures and interventions requiring anaesthesia services.

The increasing trend to provide care to patients with significant comorbidities and at the extremes of age as well as provision of increasingly complex procedures, needs to be addressed to ensure that patients continue to receive the highest standards of care. Some of the specific risks are considered in the body of these guidelines.

Occasionally, even with the best possible care, some patients scheduled for DSP will need to be admitted to a healthcare facility with inpatient care capability. With increasing patient acuity and surgical complexity this may become more common. There should be a pre-arranged mechanism for this to occur, particularly in "stand alone" or "free standing" facilities.

4. Selection guidelines for DSP

In all cases, the ultimate decision as to the suitability of any patient for DSP is that of the anaesthetist who will be administering the anaesthesia. The decision as to the type of anaesthesia is the responsibility of the medical practitioner administering anaesthesia and will be based on the following:

- Selection of patients and anaesthesia considerations.
- Surgery/procedure considerations.
- Recovery (PACU) and discharge arrangements.
- Adequacy of resources, including personnel, of the DSP facility.
- Geographic location of the DSP Facility for example urban versus rural.
- Type of facility for example "free-standing" (this includes office/rooms-based facilities) or co-located/in close proximity to a tertiary/quaternary hospital.

5. Patient selection and anaesthesia factors

5.1 Patients should be of ASA physical status 1 or 2 or medically stable ASA 3 or 4 patients. Note that ASA physical status alone does not dictate acceptability as this will also be influenced by surgical/procedural factors and the facilities of the DSP unit. The psychosocial advantage of short duration stay in an unfamiliar environment is being increasingly recognised for the elderly but this has to be weighed up against optimal management of comorbidities. When considering whether DSP is appropriate for patients with significant medical issues, early consultation with the involved anaesthetist is essential.

5.2 Careful assessment of medical comorbidities should be undertaken in all patients with particular attention to allergies, obstructive sleep apnoea (OSA) or sleep disordered breathing as well as the potentially difficult airway. Such assessment is particularly relevant in obese patients. In any given healthcare facility a nominal BMI should be established above which patients would be referred for early consultation with an anaesthetist.

A value greater than 35 kg/m2 is commonly used. Validated screening tools for assessment of suspected OSA may be useful in assessing a patient's suitability. Patients with confirmed or suspected OSA should have minimal postoperative opioid requirement and ideally discharge

analgesia should not include opioids. Patients with cardiac implantable electronic devices (CIEDs) should have the devices checked to ensure correct functioning.[3]

Maximum acceptable patient weight for any facility will be determined by factors including mechanical ratings of equipment and fixtures to allow safe manual handling, care of the patient and transport within the DSP facility.

5.3 Infants and children are suitable provided specific arrangements for their treatment are made.

6. Surgical/procedural considerations

Increasingly complex surgical procedures are being performed as day stay procedures. The concept of "23 hour admission" in some facilities has enabled the conduct of more complex procedures that would normally have been undertaken as inpatient procedures.

The procedure/surgery to be performed should:

6.1 Have a minimal risk of postoperative haemorrhage.

6.2 Have a minimal risk of postoperative airway compromise.

6.3 Be amenable to postoperative pain controllable by outpatient management techniques.

6.4 Permit postoperative care to be managed by the patient and/or a responsible adult and any special postoperative nursing requirements met by day surgery, home or district nursing facilities.

6.5 Be associated with a rapid return to normal fluid and food intake.

6.6 Be scheduled taking into account the anticipated recovery period. Where a prolonged recovery is anticipated the procedure should be scheduled first on the list or as close to first as feasible.

7. Post-anaesthesia care and discharge arrangements

7.1 **Post Anaesthesia Care Unit (PACU) – "first stage" recovery**
The requirement for facilities and staff for a PACU are contained with *PS04(A) Position statement on the post-anaesthesia care unit*.

7.2 **Post Anaesthesia Care – "second stage" recovery**
An area should be provided with comfortable reclining seating for patients during the second stage of recovery prior to discharge home. This area should be adequately supervised by nursing staff and also have ready access to resuscitation equipment, including oxygen and suction. Patients should not leave this area unaccompanied.

7.3 **Discharge or Transfer of Patient**
Discharge planning and arrangements should occur prior to admission and be confirmed on admission.

The following criteria should be satisfied prior to patients being discharged home:

7.3.1 Stable vital signs.

[3] Refer to guidelines for the management of patients with CIEDs referenced below.

7.3.2 Conscious state that is similar to pre-anaesthesia levels.

7.3.3 Mobility level that is similar to pre-anaesthesia levels with allowance for type of surgery and/or regional anaesthesia techniques.

7.3.4 Adequate pain control.

7.3.5 Manageable nausea, vomiting or dizziness.

7.3.6 Tolerating oral fluids.

7.3.7 Minimal bleeding or wound drainage.

7.3.8 Patients at significant risk of urinary retention (central neural blockade, pelvic and other surgery) should have passed urine.

7.3.9 Written and verbal instructions for all relevant aspects of post-anaesthesia and surgical care have been provided to patients or their accompanying adult. It should be established that patients and/or their responsible person understand the requirements for post anaesthesia care and intend to comply with these requirements, particularly with regard to public safety. A contact place and telephone number for emergency medical care should be included.

7.3.10 Patients have received advice as to when to resume activities such as driving and decision making.

7.3.11 Analgesia has been provided where necessary, with clear written instructions on how and when medications should be used. Careful consideration should be given when prescribing opioids on discharge.

7.3.12 Advice has been provided on resumption of other regular medications.

7.3.13 Discharge has been authorised by a member of the medical team or trained nurse after discharge criteria have been satisfied.

7.3.14 A responsible adult is available to transport the patient and should 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 unit. This person should be physically and mentally able to make decisions for the patient's welfare when necessary.

7.3.15 If the patient is to be transferred to an inpatient facility, the anaesthetist and/or the surgeon will be responsible for the patient until care has been transferred to another medical officer in accordance with *PS53(A) Position statement on the handover responsibilities of the anaesthetist*.

8. Adequacy of resources

8.1 Facilities should be licensed or meet the equivalent standards, including compliance with relevant building code in Australia and New Zealand.

8.2 Appropriately qualified staff, adequate numbers of staff, provision of appropriate equipment (including resuscitation equipment) should be provided and available. *PG09(G) Guideline on procedural sedation* gives guidance in these areas.

8.3 Incident/adverse event management and reporting, should be recorded and documented.

8.4 Infection control policies consistent with the National Standards as well as *PG28(A) Guideline on infection control in anaesthesia* should be available.

8.5 Compliance with drug handling standards and *PG51(A) Guideline for the safe management and use of medications in anaesthesia* should be ensured.

8.6 Emergency access (including mechanisms for transfer of patients to another healthcare facility if required) should be available as well as ambulance access to aid transfer to inpatient hospital care when this is necessary.

8.7 The discharge area should be accessible by wheelchair and parking facilities located in close proximity to minimise walking.

9. Audit

Each day care unit should have an established system for audit of the outcomes related to anaesthesia care, and include these outcomes in quality assurance and peer review processes. Audits should include recording delayed discharge, unanticipated transfer of patients to other facilities for ongoing care, and failure to comply with discharge instructions.

Ideally, each DSP facility should have a Clinical Lead who has a specific interest in DSP. Part of their job description should include audit as well as the development of guidelines, and policies.

This document is accompanied by a background paper (PG15(POM)BP) which provides more detailed information regarding the rationale and interpretation of the Guideline.

References

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Related ANZCA documents

PS02(A) Position statement on credentialling and defining the scope of clinical practice in anaesthesia

PG03(A) Guideline for the management of major regional analgesia

PS04(A) Position statement on the post-anaesthesia care unit

PG06(A) Guideline on the anaesthesia record

PG07(A) Guideline on pre-anaesthesia consultation and patient preparation

PG09(G) Guideline on procedural sedation

PG18(A) Guideline on monitoring during anaesthesia

PS19(A) Position statement on monitored care by an anaesthetist

PS26(A) Position statement on informed consent for anaesthesia or sedation

PG28(A) Guideline on infection control in anaesthesia

PG29(A) Guideline for the provision of anaesthesia care to children

PG41(PM) Guideline on acute pain management

PS45(G) Position statement on patients' rights to pain management and associated responsibilities

PG51(A) Guideline for the safe management and use of medications in anaesthesia

PS53(A) Position statement on the handover responsibilities of the anaesthetist

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