

## Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNET)

### 23 Hour Ward Admission Criteria

#### 1. Purpose

This guideline provides recommendations to inform and guide the development and implementation of 23 hour wards in Queensland Health facilities.

#### 2. Scope

This guideline applies to all Queensland Health employees (permanent, temporary and casual), its agents (including Visiting Medical Officers and other partners, contractors, and consultants) involved in the admission of patients to short stay / 23 hour wards.

#### 3. Related documents

- A Victorian Government initiative: extended day surgery
- NSW Government Health: high volume short stay surgical model toolkit
- Australian and New Zealand College of Anaesthetists Recommendations for the Perioperative Care of Patients Selected for Day Care Surgery
- Princess Alexandra Hospital: patient selection—extended stay unit
- Royal Brisbane and Women's Hospital: 23 hour unit admission and discharge criteria
- Australian Council of Healthcare Standards (ACHS)
- Clinical Access and Redesign Unit, Criteria Led Discharge service delivery model

#### Document details

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## SWAPNET Guideline - 23 Hour Ward Admission Criteria

### Disclaimer:

These guidelines have been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. Information in this guideline is current at time of publication.

Queensland Health does not accept liability to any person for loss or damage incurred as a result of reliance upon the material contained in this guideline.

Clinical material offered in this guideline does not replace or remove clinical judgement or the professional care and duty necessary for each specific patient case.

Clinical care carried out in accordance with this guideline should be provided within the context of locally available resources and expertise.

This Guideline does not address all elements of standard practice and assumes that individual clinicians are responsible to:

- Discuss care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes the use of interpreter services where necessary
- Advise consumers of their choice and ensure informed consent is obtained
- Provide care within scope of practice, meet all legislative requirements and maintain standards of professional conduct
- Apply standard precautions and additional precautions as necessary, when delivering care.
- Document all care in accordance with mandatory and local requirements.

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## 4. Guideline for 23 Hour Ward Admission Criteria

### 4.1 23 hour care

23 hour care models recognise that selected procedures, not otherwise suitable for day surgery, can be provided within a 23 hour period in a non-inpatient environment. In these units, patients can be monitored post-operatively and discharged within 23 hours.

The fundamental components of effective 23 hour care models are:

- appropriate patient selection using predetermined admission criteria
- use of clinical protocols to plan, implement, monitor and report a patient's progress within the clinical pathway, including admission and discharge
- quarantined beds for surgery in close proximity to operating theatres if possible
- clearly defined roles and expectations for staff and service providers that assist with the provision of 23 hour care
- criteria led discharge.

The implementation of 23 hour models of care has been associated with service improvements including:

- improved operating theatre utilisation
- reduced waiting lists
- improved access to post-operative beds and operating theatre sessions
- reduced length of stay
- fewer hospital initiated postponements
- fewer unplanned overnight stays
- improved communication between medical, nursing, pharmacy, allied health and administrative staff.

23 hour units can provide a transitional service where there is uncertainty about whether to transfer the routine performance of a procedure from overnight to day surgery care.

23 hour models of care are not an alternative or substitute for day surgery but an extension of services for patients unsuitable for day surgery.

### 4.2 Screening and suitability

#### 4.2.1 Screening

The role of the patient screener is to ensure that patients eligible for 23 hour care are identified and clinically assessed for suitability. The patient screener should be a clinician experienced in the management of patients undergoing short-stay surgery.

Proposed admissions to the 23 hour unit should be screened according to locally developed criterion (screening tool) that determines a patient's suitability for admission.

### 4.2.2 Procedures suitable for day care surgery

Must be based on:

- A minimum risk of post-operative haemorrhage
- A minimal risk of post-operative airway compromise
- Post-operative pain controllable by outpatient management techniques
- Post-operative care managed by the patient and/or a responsible adult and any special post-operative nursing requirements met by day surgery, home or district nursing facilities
- A rapid return to normal fluid and food intake
- Operative list organisation to achieve early commencement of procedures for which a long recovery period is unlikely
- The patient is able to:
  - use unit facilities with minimal assistance and have independent management of continence
  - mobilise with low level assistance
  - perform activities of daily living with minimal assistance
- Patients who have received cytotoxic therapy within 7 days of procedure must be flagged within the patient notes as an alert and the 23 hour unit notified to assist with patient management.

### 4.3 Patient admission criteria

Appropriate patient selection is one of the key elements of successful implementation of 23 hour care models.

It is the responsibility of the surgeon, anaesthetist and nursing staff to select patients suitable for admission to the 23 hour unit with maximum regard for safety and maintenance of professional standards.

Admission criterion determines the scope of the service to be provided by the 23 hour unit.

A 23 hour clinical pathway is required for all admissions to the 23 hour unit.

Refer to:

- 23 Hour Ward Patient Selection Flow Chart (Appendix1)
- [Day Surgery Clinical Pathway – Extended day surgery / Day only](#)

### 4.3.1 Suitability of patients

#### 4.3.1.1 Medical

- American Society of Anaesthesiologists (ASA) physical status of I or II or medically stable ASA III or IV patients. Physical status alone does not dictate acceptability. Early consultation with the anaesthetist involved is essential. Refer to ASA Physical Status Classifications (Appendix 1).
- Body Mass Index (BMI)  $< 35/m^2$ . Obesity may not be a contraindication for short stay treatment where facilities are able to manage these patients. Patients who may be ineligible for day-only surgery may be suitable for 23 hour care. Refer to BMI Classifications (Appendix 1).
- Patients with chronic but stable comorbidities such as well controlled diabetes and CPAP/BIPAP users may be considered (in consultation with the anaesthetist) to be suitable for admission to 23 hour care.
- Myocardial infarction not less than 6 months.
- Patients less than three years of age or over 80 years of age may be excluded from short stay surgery due to inadequate support systems. Patient selection should be undertaken according to psychosocial status rather than age alone.

#### 4.3.1.2 Social

- The patient must be willing to have the procedure performed, have an understanding of the process and the ability to follow discharge instructions.
- Non-English speaking patients may require the assistance of an interpreter.
- The patient and their immediate carer must understand the post-operative care requirements (including when to resume activities such as driving and decision making).
- The carer must be willing to accept responsibility for supervising the patient's recovery at home for at least the first 24 hours.
- Suitable arrangements must be available for transport home at the nominated discharge time.
- If the journey home is likely to take more than one and a half hours, the patients' needs including pain control should be reviewed and the patient's immediate carer advised of the need to consider breaking the journey for a rest.
- The patient and immediate carer must have direct access to a telephone (land line or mobile) and ability to contact the hospital if required.

## SWAPNET Guideline - 23 Hour Ward Admission Criteria

- The patient's place of residence for post-surgery care must be within one hours travelling time from appropriate postoperative medical attention.
- Airline travel has some unique features which must be considered by passengers with medical conditions to ensure a safe flight.
- Refer to:  
QANTAS medical assistance:  
<http://www.qantas.com.au/travel/airlines/medical-assistance/global/en>

[Queensland Government: Your Short Stay Surgery \(information for patients and carers\)](#)

SWAPNET Anaesthesia: non-bariatric surgery in obese patients:  
<http://www.health.qld.gov.au/qhpolicy/docs/gdl/qh-gdl-395.pdf>

### 4.3.1.3 Paediatric

- Paediatric social criteria depends on the age and maturity of the child. Health services should consider admission criteria based on clinical assessment and in consultation with children and their parents or carers.  
The parent must:
  - Agree to 23 hour care treatment
  - Assist with the preadmission process
  - Care for the child after treatment
  - Make arrangements for the care of the child at home as required following discharge.
- It is strongly recommended that the parent remain with the child for the duration of the admission.
- Australian and New Zealand College of Anaesthetists (ANZCA) professional Document PS29 *Statement on Anaesthesia Care of Children in Healthcare Facilities Without Dedicated Paediatric Facilities* is relevant to the management of infants and children for 23 hour care.

### 4.3.2 Exclusion criteria

Complex patients often require active management to facilitate timely access to surgery. A referral guide should be developed to assist in the preparation of otherwise unsuitable patients for 23 hour care. Protocols should be developed to assist the screener to manage complex patients. The protocols may include access to outpatients or pre-admission appointment slots or access to allied health services.

Patients may not be suitable for 23 hour care for a range of clinical or social reasons. Referring practitioners should be encouraged to advise the health

service of circumstances that cause patients to be unsuitable for 23-hour surgery at the time of referral.

Patients unsuitable for admission to 23 hour units may include:

- Security unit patients, detention centre patients
- History of and / or unstable mental illness, excessive aggression or abnormal psychological behaviour uncontrolled by medication, Alzheimer's or dementia
- VRE or MRSA alert
- Epidural analgesia
- Bladder irrigations
- Airway difficulties, tracheostomy
- Bariatric
- Anticipated or complicated recovery period.

Border babies may be accommodated if the facility has access to related services.

Refer to:

Queensland Health protocol for the management of patients with Vancomycin Resistant Enterococcus (VRE)

<http://www.health.qld.gov.au/chrisp/resources/vre.asp>

#### 4.4 Patient Clinical Pathway

Clinical pathways are standardised, evidence-based multidisciplinary management plans that identify an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group and should be used to support the effective management of patients.

Refer to:

[Queensland Health, Clinical Pathways, Surgical Pathways](#)

#### 4.5. Discharge criteria

Protocol driven discharge also known as Criteria Led Discharge (CLD) and Nurse Initiated Discharge is an essential component of an effective 23 hour unit and will contribute to improved patient experience by facilitating timely discharge and more productive use of available beds.

The Queensland Health Clinical Access and Redesign Unit Criteria Led Discharge (CLD) service delivery model has been developed to improve the patient journey and experience, reduce delays, increase access to services and provide best clinical practice across Queensland.

CLD enables clinicians, aside from medical specialists, with the necessary knowledge, skills and competencies to review patients and initiate inpatient discharge. This process is supported by predetermined criteria, policies and procedures which have multi-disciplinary agreement.

Where medical discharge is desirable, the identity of the contact details of the doctor responsible for discharge is documented with the expected time of discharge.

Not all patients may be suitable for CLD and in such cases, a commitment from the treating surgeon to complete the discharge requirements within the 23-hour timeframe should be obtained as a condition of accepting referrals to the unit.

Refer to:

Clinical Access and Redesign Unit - Criteria Led Discharge

<http://qheps.health.qld.gov.au/caru/cld/default.htm>

### 4.6 Follow up / post discharge management

A designated officer (eg. registered nurse responsible for the patient) should provide written and verbal instructions to the patient and / or carer regarding relevant aspects of their post anaesthetic and surgical care. The patient should also be provided with a telephone contact number for emergency medical care. All information provided should be recorded in the patient's medical record.

### 4.7 Evaluation

The purpose of evaluation is to provide information to assist in identifying opportunities for improvement, address problems and build on existing strengths to further develop service delivery. Reliable information about the performance of 23 hour units will build a better understanding of how the service impacts patients, their carers, clinicians, service providers and interested stakeholders.

Evaluating the performance of the 23 hour unit is an effective way to include stakeholders in service reform, drive improvement strategies and facilitate benchmarking between similar units.

The Australian Council of Healthcare Standards (ACHS) provides clinical indicators for monitoring day surgery performance. The day surgery indicators are not a mandatory component of a health service's accreditation but assist in demonstrating an effective day surgery service.

Refer to:

ACHS, CI 1.1 – 1.4 which reflects the operational and administrative processes implemented by health services that facilitate access to surgery. These indicators recognise the importance of optimal utilisation of perioperative services.

ACHS, CI 2.1, 3.1 and 4.1 which relate to safety issues and reflect complications that arise in carrying out procedures.



## SWAPNET Guideline - 23 Hour Ward Admission Criteria

Further information regarding day surgery indicators is available at the ACHS website: [www.achs.org.au](http://www.achs.org.au)

### 5. Review

This Guideline is due for review on: 1 March 2015

Date of Last Review: N/A

Supersedes: New document

### 6. Business Area Contact

Clinical Access and Redesign Unit, Health Systems Innovation Branch

### 7. Guideline revision and approval history

Version No.	Modified by	Amendment schedule	Approved by
v0.01	Karen Hamilton	First draft presented at the inaugural 23 Hour Ward Work Group meeting on 22 April 2013	Elaine Hausler, Chair, Perioperative NUMs Advisory Group
v0.02	Karen Hamilton	Amended and reviewed by the work group on 27 May 2013	Elaine Hausler, Chair, Perioperative NUMs Advisory Group
v0.03	Karen Hamilton	Amended and reviewed by the work group on 24 June 2013	Elaine Hausler, Chair, Perioperative NUMs Advisory Group
v0.04	Karen Hamilton	Endorsed by the SWAPNET Steering Committee on 30 August 2013	Peter Moran and Helen Werder, Co-Clinical Chairs, SWAPNET
v0.05	Karen Hamilton	Endorsed by the Surgical Advisory Committee on 14 October 2013	Ian Gough, Chair, Surgical Advisory Committee
v0.06	Karen Hamilton	Distributed to Hospital and Health Services for consultation on 19 November 2013	Michael Cleary, Deputy Director-General, health Service and Clinical Innovation Division
V0.07	Karen Hamilton	Reviewed and amended by the work group on 10 February 2014	Elaine Hausler, Chair, Perioperative NUMs Advisory Group
V1.0	Karen Hamilton	Final draft	Michael Cleary, Deputy Director-General, health Service and Clinical Innovation Division

### 8. Approval and Implementation

#### Policy Custodian:

Chief Allied Health Officer

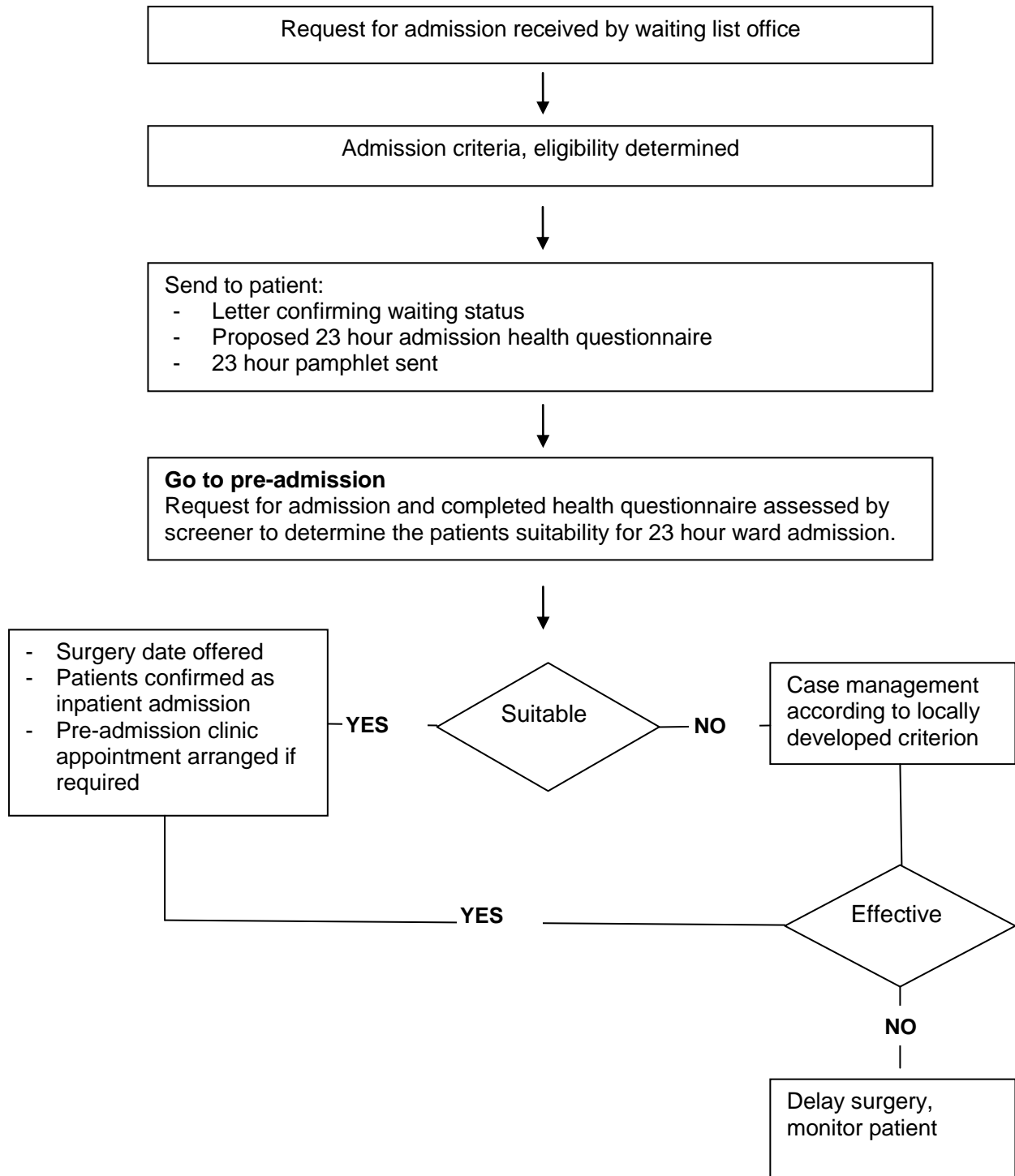
**Approving Officer:**

Dr Michael Cleary, Deputy Director-General, Health Service and Clinical Innovation

**Approval date:** 25 February 2014

**Effective from:** 1 March 2014

**23 Hour Ward Patient Selection Flow Chart**



A patient is eligible when the proposed procedure is performed on a 23 hour basis.

A patient is suitable when after screening the patient meets the clinical and social admission requirements for 23 hour surgery.

### BMI Classification

Body Mass Index (BMI) is a simple index of weight for height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m<sup>2</sup>).

The World Health Organisation (WHO) international classification of adult underweight, overweight and obesity according to BMI is as follows:

Classification	BMI(kg/m <sup>2</sup> )	
	Principal cut-off points	Additional cut-off points
<b>Underweight</b>	<b>&lt;18.50</b>	<b>&lt;18.50</b>
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
<b>Normal range</b>	<b>18.50 - 24.99</b>	<b>18.50 - 22.99</b>
		<b>23.00 - 24.99</b>
<b>Overweight</b>	<b>≥25.00</b>	<b>≥25.00</b>
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
<b>Obese</b>	<b>≥30.00</b>	<b>≥30.00</b>
Obese class I	30.00 - 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

### Physical Status Classification

The American Society of Anaesthesiologists (ASA) physical status classification categorises obese patients as ASA 2 and those with measured organ dysfunction (eg. diabetes) as ASA 3. It is acknowledged that a waist-height index has a more direct relationship with morbidity however currently Body Mass Index (BMI) is more commonly measured.

It should be noted that the ASA principal cut off points for BMI classification are slightly different to the WHO international classification as follows:

Obese Class I – BMI 30-35

Obese Class II – BMI 36-40

Obese Class III – BMI 41-49 (+morbid obesity or extreme obesity)

Super Morbidly Obese BMI > 50