

# Emergency Surgery Access

## 1. Statement

The Emergency Surgery Access Guideline (the guideline) outlines the minimum suite of business rules and processes required to ensure that all patients requiring emergency surgery at Queensland public hospitals have timely access to treatment and all Queensland public hospitals providing emergency surgical care have defined principles and standards for service provision.

This guideline does not replace, but is additional to, the professional self-regulation and individual accountability for clinical judgement that are integral components of healthcare. It does not incorporate or relate to individual clinical specialty defined best practice standards.

## 2. Scope

This guideline applies to all admitted patients who are clinically assessed as requiring emergency surgery at a public hospital in Queensland referred to hereafter as a Hospital and Health Service (HHS). Emergency surgery includes procedures performed under anaesthesia.

The Australian Institute of Health and Welfare (AIHW) *Metadata Online Registry (METeOR) – Emergency Surgery Standard* defines emergency surgery as surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission. Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).

Queensland Health applies this definition to eligible patients for a period of up to 10 days from the point a decision of the need for emergency surgery is made. Surgery that is delayed to a time beyond 10 days from the decision point is considered elective surgery.

Compliance with this guideline is not mandatory, but sound reasoning must exist for departing from the recommended principles within a guideline.

### Out of scope

This guideline does not apply to the following:

- Elective surgery not linked to an emergency surgery assessment
- Obstetrics
- Procedures that are not publicly funded in Queensland.

## 3. Requirements

### 3.1 Eligibility

Eligible patients are those patients who have a condition that has been medically assessed as requiring emergency surgery; such as traumatic injuries, acute illness, or deterioration in existing conditions.

Patients requiring emergency surgery can be:

- admitted to the hospital via emergency departments
- currently admitted inpatients who experience a sudden deterioration in their health
- admitted to the hospital via specialist outpatient services.

Individual surgical specialities should define what constitutes a clinical emergency requiring immediate operative intervention within their specialty area and hospital.

### 3.2 Classification

Classification of surgical patients is determined by the planned or unplanned nature of approach. In Queensland, emergency surgery is considered to be unplanned in its nature and may extend for up to 10 days from the time a decision for surgery is made. The extended time period of up to 10 days accommodates those patients who require emergency surgery but who cannot be operated on for clinical reasons (e.g. until swelling has reduced). Surgery scheduled beyond 10 days is considered to be planned in nature, be it an initial or staged procedure, and therefore is considered elective surgery.

Patients who present to emergency departments, are current hospital inpatients, or are seen in outpatient services and are clinically assessed as having a condition requiring emergency surgery, are to be classified as emergency surgery patients for up to 10 days (as per emergency surgery priority categories) from the time a decision for surgery is made.

Patients that are classified 'emergency surgery' require completion of an emergency surgery booking form (see Section 3.6).

Patients discharged home for clinical reasons with a booked date to return for surgery within 10 days will remain classified as emergency surgery patients.

Patients with a booked date to return for surgery beyond 10 days from the time a decision for surgery is made will be classified as elective surgery patients.

Those patients classified as elective surgery require:

- completion of an elective surgery admission booking form
- registration on the elective surgery waiting list with ongoing management as per the Elective Surgery Implementation Standard.

All patients undergoing a surgical procedure (emergency or elective surgery classifications) should have some form of pre procedure preparation to ensure a maximum level of fitness/willingness and availability for surgery.

### 3.3 Priority categorisation

Emergency surgery patients are those whose clinical acuity has been assessed as to require surgery within 10 days of the decision being made. By virtue of their medical condition, these patients are

often critically ill, clinically complex and highly vulnerable and need to be prioritised for surgery ahead of patients scheduled for elective surgery where clinically indicated.

To differentiate urgency, patients who require emergency surgery are to be assigned a priority category appropriate to the patient and their clinical situation, without influence by the perceived or actual availability of resources. The clinical situation is to take into consideration the patient's presenting medical condition and comorbidities, associated urgency for surgical intervention and potential ramifications of any delay.

A decision to operate after hours (22:00hrs – 08:00hrs) should be based on consideration of the magnitude of clinical risk to patient survival and well-being if that operation is not performed urgently.

#### Queensland emergency surgery priority categories

Priority Categories	Clinical descriptor / Physiological status	Time frame
A	Immediate: Patient is in immediate risk of loss of life or loss of limb, shocked or moribund. The patient may or may not be responding to resuscitation measures. Requires a theatre to be made available immediately.	<1 hour
B	Critical: Patient is physiologically stable but there is immediate risk to organ survival or systemic decompensation or the surgical problem may undergo significant deterioration if left untreated. Requires next available emergency or non-emergency theatre.	<4 hours
C	Priority: Patient's condition is stable but the surgical problem may undergo significant deterioration if left untreated.	<24 hours
D	Non critical: Patient is admitted to hospital as an inpatient and scheduled for emergency surgery within 10 days of the decision for surgery being made	< 10 days
E	Non critical: Patient is sent home to return for scheduled emergency surgery within 10 days of the decision for surgery being made	< 10 days

Patients that are allocated a date for surgery beyond 10 days from the time the decision is made are to be categorised as elective surgery category 1-3:

- Category 1 – procedures that are clinically indicated within 30 days
- Category 2 – procedures that are clinically indicated within 90 days
- Category 3 – procedures that are clinically indicated within 365 days

Priority categories are to be assigned by senior medical staff, that being the treating specialist or surgical registrar, prior to the patient being registered on the operating theatre information management system. In regional and rural or remote facilities, the equivalent senior medical staff would be the most senior medical officer available or on call.

If there is any uncertainty of the appropriate priority category for the patient's clinical condition, the surgical registrar, or equivalent, is to discuss any issues or concerns with the relevant specialist surgeon or specialist anaesthetist.

Patients prioritised to category D and E should have their surgery performed within safe operating hours (08:00hrs – 22:00hrs) wherever it is clinically appropriate to do so.

For Category E patients, the need for further pre admission review/s and pre admission clinic attendance should be considered and coordinated as required.

Patients within a category whose surgery has been delayed beyond the respective time frame should be prioritised for theatre ahead of patients in the same category that are waiting in time.

### **Red Blanket Procedure**

The Red Blanket procedure was developed for and applies specifically to trauma patients. While the procedure applies only to trauma under this guideline, HHSs with a Red Blanket policy or procedure are able to extend application to other locally determined clinical conditions at their own discretion as the HHS considers appropriate.

A 'Red Blanket' procedure is activated to coordinate the rapid unimpeded transfer of a non-responsive trauma patient with haemodynamic instability to the operating theatre for immediate surgical management of suspected uncontrollable bleeding.

Red Blanket procedures are incorporated under priority category A, <1 hour and can be reported separately within defined parameters as required.

Red Blanket patients can be transferred to the operating theatre from emergency departments or directly from helipads, under the care and direction of the accepting specialist surgeon and emergency department clinical staff, bypassing usual hospital rules.

Each HHS providing a Red Blanket emergency surgery response for trauma patients should develop a local procedure to ensure clarity of patient eligibility, roles and processes.

If Red Blanket activation is thought to have been made inappropriately, the case should be referred to the Director of Surgery for review and action as appropriate.

### **3.4 Access to emergency surgery**

Access to publically funded emergency surgery occurs:

- via HHS emergency departments
- via HHS inpatient wards/units
- via HHS specialist outpatient services.

If emergency surgery is a key component of a hospital's core business it needs to be managed according to a hospital's capability to provide the required service. The responsibility of HHSs to provide emergency surgery is determined by:

- self-assessed surgical service capability (as defined by Queensland Health's Clinical Services Capability Framework - CSCF)
- the volume and type of surgical activity that a HHS can provide
- availability of medical staff with admitting and operating rights for the hospital.

Facilities that have the capability and do provide emergency surgery services should:

- ensure emergency surgery services are available onsite or accessible (as per CSCF) 24 hours a day every day of the year
- perform emergency surgery within safe operating hours wherever it is clinically appropriate to do so (08:00hrs – 22:00hrs)
- ensure medical staff rostered for emergency surgery have flexible duty arrangements that enable availability at short notice (30 minutes) and minimal elective surgery operating responsibilities the morning following an overnight roster (dependent on facility profile).

Where a facility does not have the capability to provide an emergency surgery service, or a patient's condition cannot be managed by the clinicians in the receiving facility, Queensland Health inter-hospital transfer/retrieval protocols and local escalation processes need to be initiated and adhered to, to effect safe and expedited transport to an appropriate facility for care.

Supporting service requirements for emergency surgery include on-site or access to:

- operating theatre/s
- senior surgical and anaesthetic staff
- senior nursing staff
- senior radiology
- pathology
- critical care facilities
- sterilisation services

It is the responsibility of each HHS to determine local access models, solutions and delegations that meet local need and capacity and enhance access (e.g. dedicated emergency and/or specialty emergency theatres, Acute Surgical Units).

Dedicated emergency theatres should be considered where demand/caseloads are high:

- 30% or more emergency cases wait longer than the recommended time for surgery
- 30% or more emergency theatres run over time (after 2200hours)
- 2 or more emergency lists are required per day to meet demand.

Facilities with a dedicated trauma surgery team should not reallocate team members to support elective activity unless agreed to by the trauma consultant for that day. If this is agreed, the circumstances should be documented according to standard local operational processes.

The Department of Health (DoH) will build tools to monitor emergency surgery activity and performance which will support local assessment of a services capability to meet the needs of the HHS population.

### **3.5 Scheduling emergency surgery**

Critically ill patients need to be prioritised for surgery before non-critical or elective surgery patients.

All patients, including current inpatients, which are assessed as requiring emergency surgery, should be placed on the emergency board/list rather than the elective surgery (Category1) list. However, to

ensure operating theatres are used optimally, any unused elective surgery session time should be allocated to emergency cases on a clinical priority basis.

When clinically appropriate, trauma cases should be allocated to an in-hours emergency theatre list or the next most appropriate surgical in-hours list.

All emergency surgery patients require an emergency surgery booking form to be completed and to be registered in the operating theatre information management system.

To ensure accurate calculation of priority category timeframes, the date and time the decision for surgery is made should be documented on the emergency surgery booking form. Consistent and appropriate processes for monitoring category breach times using the operating room management information system should be established; to reflect emergency surgery waiting times calculated for each priority code from the time a decision for emergency surgery is made to the procedure start time.

The specialist surgeon and specialist anaesthetist are required to be informed and available at the time surgery is scheduled to commence. In the instance that the specialist surgeon allocated to the emergency surgery list is not available, a specialist surgeon allocated to an elective surgery list may be required to perform or supervise the surgery. The decision to proceed with this plan is only made following discussion and agreement between the specialist surgeons concerned.

Radiology should be notified of requests for services and specific medical imaging equipment at the time the decision for surgery is made.

Communication processes between theatre and radiology should be clearly identified to ensure radiology services are provided with the greatest amount of time to organise and allocate staff and equipment to theatre services to ensure emergency surgery commences on time.

Patient flow managers and/or bed managers should be informed to coordinate and secure availability of the most appropriate post-operative bed for the patient.

The need for specialty unit care (e.g. critical care units) should be considered for each emergency surgery case and where indicated, communication between the specialist surgeon, specialist anaesthetist and specialty unit consultant should occur pre and post-operatively.

Where there is conflict regarding surgical priorities (assigned code, list placement), or the emergency surgery theatre board/list is oversubscribed, the specialist surgeon and specialist anaesthetist concerned and the theatre shift coordinator, are to discuss and decide on a plan to resolve the issue/s. Where resolution cannot be reached, the issue should be escalated to Departmental heads/Directors.

All facilities providing emergency surgery should have locally determined escalation processes in place to support decision making and accountability with respect to managing demand: resource capacity, case prioritisation, cancellations/delays, theatre over runs, team communication, clinical supervision and conflicts.

### **3.6 Booking form**

Once a decision is made by the specialist surgeon to proceed with emergency surgery, a valid emergency surgery booking form is required to be completed by the specialist surgeon or surgical registrar. The following information should be included at minimum:

- patient identification details
- patient contact details
- patient consent
- priority category
- date/time of decision for surgery
- requested date/time for surgery
- procedure details
- specific equipment required
- medical imaging notification
- specialist surgeon name and contact details
- specialist surgeon or surgical registrar authorisation
- specialist surgeon availability – operating, supervising
- critical care unit bed required.

Red Blanket cases are an exception to these requirements with documentation able to be completed during or post-operatively.

Incomplete forms cannot be processed which may result in delays to patient bookings. If an incomplete emergency surgery booking form is received, the theatre shift coordinator or equivalent clinical delegate will need to contact the treating specialist or surgical registrar to complete the booking details.

Information from the emergency surgery booking form is to be entered into the HHS operating theatre information management system to:

- create the operation booking request which in turn enables prioritised scheduling of emergency cases
- form the basis of the operation record.

Procedures undertaken during theatre that are additional or an alternative to the anticipated procedure are to be entered and/or updated in the operation record within the operating theatre information management system during surgery.

### **3.7 Emergency surgery board/list**

Emergency surgery patients will be booked on the emergency surgery board/list when the decision for surgery is made and a booking form has been received. The order of bookings will be based upon the patients designated priority category and thereafter by the time of booking. The allocation of emergency surgery patients to theatres is the responsibility of operating theatre staff.

Emergency surgery patients scheduled for surgery within 10 days from the time of booking will be placed on the emergency surgery board/list by the specialist anaesthetist, theatre shift coordinator, or bookings officer. The administrative management of Category E patients once scheduled is to be determined by individual HHSs.

As outlined in section 3.3, patients scheduled for surgery in excess of 10 days from the time of booking will be placed on the elective surgery waitlist and assigned urgency category 1 - 3. The ongoing management of these patients will be under the remit of the elective surgery coordinator and as per the Elective Surgery Implementation Standard.

Where clinically appropriate, every attempt to avoid patients being operated on out of safe operating hours should be exhausted.

### 3.8 Patient consent

A valid Queensland Health consent form signed by the relevant specialist/s or surgical registrar and the patient or their legal guardian, or verbal informed consent, is to be obtained from the patient or their legal guardian wherever possible, and a notation made in the patient's medical record. Where required (e.g. semi-urgent or mental health cases), advice can be sought from the Office of the Public Guardian (Phone: 1300 7103 624).

In circumstances where it is only practical to obtain verbal informed consent for surgery, the following processes are to be followed:

- The 'verbal informed consent' box on the emergency surgery booking form is to be completed by the specialist/s or surgical registrar who obtained verbal informed consent from the patient or their legal guardian, signed and dated.
- A notation is to be made in the patient's medical record, documenting the verbal informed consent process.

If emergency surgery booking forms are submitted without evidence of informed consent, i.e. a notation on the booking form, the theatre shift coordinator or equivalent clinical delegate is to contact the treating specialist or surgical registrar to verify consent. Substantiating documentation (consent form, chart entry) is to be sighted by the receiving theatre nurse on the patient's arrival to theatre.

In circumstances where the urgency of the patient's condition (including children) necessitates rapid transfer to the operating theatre, legislation permits 'urgent healthcare' to be provided without consent from the patient or a substitute decision-maker, when a health practitioner (specialist/s or surgical registrar) reasonably considers the patient lacks the capacity to decide, and the healthcare needs to be carried out urgently to meet imminent risk to life or health or prevent significant pain or distress (*Guardianship and Administration Act 2000 (Qld)* and *Criminal Code Act 1899*).

Where the patient is a child or young person, health practitioners are expected to make reasonable attempts (considering the circumstances and time permitting) to obtain consent from the child or young person (if they are considered to be sufficiently mature to have capacity to provide consent (Gillick competent) and/or from someone with parental decision-making responsibility (*Queensland Health Guide to Informed Decision-making in Healthcare, 2012*).

The treating health practitioner (specialist/s or surgical registrar) is to document that consent was not obtained and the details of each of the criteria under which they have provided the urgent healthcare fully, including reasons, in the patient's medical record including:

- The condition being treated
- The consequence of delaying treatment
- The names of people involved in the decision making.



### 3.9 Orthopaedic emergencies (orthotrauma)

Orthopaedic emergency surgery is subject to the same requirements, classification and categorisation criteria as all other surgical specialty services under the scope of this guideline.

Orthopaedic trauma patients requiring delayed and/or multiple subsequent surgeries for a period of up to 10 days due to swelling or other clinical reasons will be classified as emergency surgery.

Surgery that requires a delay for a period of greater than 10 days due to swelling or other clinical reasons, or is part of a staged surgical regimen, should be classified as elective surgery given the planned nature of the surgical approach.

Patients requiring multiple procedures will require assessment by the treating specialist to determine the order in which procedures are to be performed and register the patient on an elective surgery waiting list as *Not Ready for Surgery – staged*.

Where there are clinical best practice time frames for specific procedures (e.g. fractured NOF), individualised performance reports for defined parameters can be generated as required.

A dedicated orthopaedic emergency theatre should be considered in facilities where workload indicates sufficient demand:

- orthopaedics comprises >50% of the emergency surgery workload
- emergency surgery lists consistently run over time
- elective surgery lists are cancelled for emergency cases >30% of the time.

Dedicated emergency orthopaedic theatre lists should not be used for elective orthopaedic surgery. Any residual capacity on an emergency orthopaedic list should be used for other patients on the emergency surgery board/list.

Where an emergency orthopaedic theatre list is at capacity, a general emergency surgery list (or equivalent) should be used, according to patient priority, for residual orthopaedic emergency surgery patients.

Orthopaedic emergency surgery lists may be interrupted to accommodate a more clinically urgent patient as determined by the specialist anaesthetist or theatre shift coordinator.

### 3.10 Cancellations

#### *Elective surgery*

Hospital-initiated cancellations are defined as any rescheduling of a patient's surgery booking date, for a reason that is related to the hospital's inability to proceed with the surgery. Emergency surgery cases will inevitably interrupt elective surgery lists resulting in the cancellation of cases some of the time. When this occurs:

- the theatre shift coordinator will review which list is most suitable to be interrupted to accommodate the emergency case and notify the affected elective surgery team, elective surgery coordinator, patient flow/bed manager and relevant units of cancellations as soon as possible
- the decision making process regarding the interruption of an elective surgery list will take into consideration:

- the urgency category of the patients on the elective surgery list (category 1 patients should not be cancelled)
- number of prior cancellations
- level of disruption to patients
- the specialist surgeon allocated to the emergency surgery case will discuss the situation with the specialist surgeon responsible for the affected theatre list as soon as possible
- HHSs will have locally determined escalation processes in place to support decision making related to elective surgery and emergency surgery cancellations
- cancellation codes are to be applied and entered into the operating theatre information system
- the management of elective surgery cancellations is to occur as per the process outlined in the Elective Surgery Implementation Standard.

### *Emergency surgery*

Emergency surgery cases will inevitably interrupt emergency surgery lists by virtue of urgency and prioritisation resulting in the postponement of scheduled emergency cases. When this occurs:

- cancellation codes are to be applied and entered into the operating theatre information system
- the postponed case will be allocated to the next available place on the emergency theatre list in accordance with the assigned priority category
- any conflict regarding surgical priorities (assigned code, list placement) will be discussed between the specialist surgeon and specialist anaesthetist concerned, and the theatre shift coordinator, to decide on a plan to resolve the issue/s. Where resolution of conflict cannot be achieved, a locally determined escalation process is to be enacted
- patients cancelled with a rescheduled date that falls beyond 10 days from the time of booking are to remain classified as emergency surgery patients (breach); they are not to be reclassified to elective surgery Category 1. The reason for the breach will be evident in the cancellation code.

In the instance where a Category E patient (planned return for surgery within 10 days) initiates a cancellation of their surgery, Cancellation code 11 (Patient requested to be removed) or 13 (Patient cancelled booking) is to be applied and entered into the operating theatre information system.

### **3.11 Role of the specialist / consultant**

Specialists are critical to achieving optimal surgical safety and clinical outcomes for patients requiring emergency surgery, and for the development and training of surgical registrars as they progress to independent operating.

The specialist should:

- lead the local model of care for emergency surgery
- lead the diagnostic work up of patients requiring emergency surgery
- delegate patients/cases to the most appropriate surgical specialty, most appropriate specialist, or surgical registrar
- endorse locally developed criteria for a clinical risk escalation process for registrars
- lead communication with patients and families/friends.

Specialist anaesthetists are responsible, in liaison with theatre shift coordinators, for organisation and patient prioritisation on emergency surgery theatre lists/sessions.

Emergency surgery lists/sessions are to be allocated to, supervised, and where clinically appropriate (critical and high risk patients) performed by, specialist surgeons.

Critically ill and high risk patients are to be operated on by or under the direct supervision of a specialist surgeon and specialist anaesthetist.

Surgical registrars and trainees need to be provided with opportunity to perform emergency surgery under the direct on-site supervision of specialist surgeons. It is essential that there is a balance brought between maximising opportunity for surgical registrars and trainees to acquire experience and competencies performing emergency surgery; safe surgical care for optimal patient outcome; and the need to cover emergency surgery rosters.

Where appropriate (as determined by facility profile), specialist surgeons should not be allocated to an elective surgery list the morning following an emergency roster allocation and should not be concurrently allocated to an emergency and an elective surgery list.

Larger facilities with a regularly high throughput of emergency cases should quarantine specialist surgeons to emergency lists, freeing them of all other commitments. Smaller facilities, or facilities with a low emergency surgery throughput, should roster specialist surgeons to emergency lists with consideration given to balancing this with scheduled responsibilities (e.g. non-theatre work when rostered for emergency surgery).

#### **4. Aboriginal and Torres Strait Islander considerations**

Queensland public hospital services and staff recognise and commit to the respect, understanding and application of Aboriginal and Torres Strait Islander cultural values, principles, differences and needs when caring for Aboriginal or Torres Strait Islander patients.

Each individual HHS is responsible for achieving successful provision of culturally appropriate services to and with Aboriginal and Torres Strait Islander individuals and their communities within the respective HHS catchment.

Equally, the respect and acknowledgement extended to Aboriginal and Torres Strait Islander people will be extended to all peoples, irrespective of ethnic background or membership of community group.

#### **5. Supporting documents**

- Emergency Surgery, Metadata Online Registry (METeOR), Australian Institute of Health and Welfare <http://meteor.aihw.gov.au/content/index.phtml/itemId/10341210>
- Patient Centred Emergency Access Health Service Directive
- Guide to Informed Decision-making in Healthcare, 2012, Queensland Health
- Guardianship and Administration Act 2000 (Qld)
- Criminal Code Act 1899
- Queensland Health Elective Surgery Implementation Standard

## 6. Definitions

Term	Definition
Comorbidities	A pathologic or disease process concomitant with but unrelated to the primary disease.
Elective surgery	Elective surgery is planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list.
Elective surgery waiting list	A repository listing all patients waiting for elective surgery and their planned surgery details.
Emergency surgery	Surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission. Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).
Hospital and Health Services	Statutory bodies with Hospital and Health Boards, accountable to the local community and the Queensland Parliament.
Priority category	A clinical priority category is applied based on a clinical assessment of the urgency with which a patient requires surgery for the treatment of an emergency condition.
Senior medical staff	Specialist (consultant) and surgical registrars
Specialist	A registered medical professional who has been assessed by an Australian Medical Council accredited specialist college as having the necessary qualifications in the approved specialty to be included on the Specialist Register. 'Specialist' is frequently used interchangeably with 'Consultant'.

## Version Control

Version	Date	Comments
v1	24/02/2016	First draft
v2	3/03/2016	Revised – incorporating feedback from Director, HIU
v3	4/3/2016	Further amendments made
v4	10/3/2016	First draft (v1) finalised for circulation/feedback
v5	3/6/2016	Feedback reviewed, incorporated and second draft (v2) circulated
v6	4/8/2016	Feedback reviewed and incorporated and approved – D. Wall
v7	22/8/2016	Draft (v3) circulated to program advisory groups – SAC, STCN, SWAPNET for final comments
v8	14/9/2016	Final version following review of feedback and last amendments by D. Wall
v9	31/10/2016	Minor additional amendment made