Emergency Surgery Management Procedure

1. Purpose

This procedure outlines the management of emergency surgery within WA Country Health Service (WACHS).

Emergency surgery is ideally to be undertaken within 48 hours. Beyond 48 hours, the surgery is considered elective and is to be booked as a Category 1 via the elective surgery wait list (refer to MP0169/21 Elective Services Access and Management Policy and WACHS Elective Surgery Waiting List Business Rules).

The effective management of emergency surgery bookings supports patient safety, a smooth transition to surgery and facilitates the efficient use of resources.

2. Procedure

Where clinically appropriate, emergency surgery should be scheduled to occur in standard theatre session hours, usually 0700hrs – 1600/1800/2030hrs Monday to Friday (as defined for each site subject to its capability). If there is no dedicated emergency theatre and where clinically indicated, emergency surgery patients should be prioritised ahead of elective surgical cases. Elective lists can be interrupted to accommodate emergency cases.

The benefits of scheduling emergency surgery during standard hours include:
- potential improved outcomes for patients
- enhanced predictability for patients, families and the surgical team with respect to scheduled operating theatre time
- reduced number of call backs and after-hours operating for the surgical team, reducing staff fatigue.

The decision to operate outside of the standard hours should be underpinned by a comprehensive risk assessment to determine if the patient will be clinically compromised if surgery is delayed.

2.1 Decision for emergency surgery, completion of booking slip and patient handover

The Consultant/Proceduralist (or their delegate), is responsible for assigning the relevant emergency surgery urgency category (as per Appendix A – WA Emergency Surgery Urgency Categories or Appendix B – RANZCOG Emergency Caesarean Section Urgency Categories as appropriate). This will allow differentiation of urgency and prioritisation of theatre access.

The Consultant/Proceduralist (or their delegate), and the Anaesthetist should discuss the risks associated with the surgery, including:
- the timing of surgery (note: the requirement for post-operative care does not outweigh the surgical urgency category)
- exploration of other therapeutic options

- consideration of alternative anaesthetic options
- transfer to a metropolitan hospital as appropriate
- communication with transport services and the receiving hospital

An Emergency Surgery Booking Slip Template (for regions to customise as required), is to be completed by the Consultant/Proceduralist (or their delegate), with all relevant details. Once completed, this should be hand-delivered to the Theatre Coordinator or the After Hours Hospital Nurse Manager/Hospital Coordinator when the Theatre Coordinator is not available. Alternatively, an electronic booking request can be completed at sites where an electronic booking system is used. (e.g. Booking Assistant Scheduling Engine (BASE)).

The Consultant/Proceduralist (or their delegate) is to contact the Anaesthetist to communicate the patient's details, including any relevant co-morbidities, allergies, Body Mass Index (BMI), any optimisation, results/investigations and fasting time expected. This should be doctor-to-doctor communication.

2.2 Scheduling emergency theatre cases

The Consultant/Proceduralist (or their delegate) must liaise with the Theatre Coordinator to ensure that emergency cases are scheduled and completed safely, as soon as practicable.

Emergency cases should be scheduled based on the following considerations:

- clinical priority (i.e. relevant emergency surgery urgency category)
- surgical team/staffing considerations (e.g. availability, fatigue management)
- Visiting Medical Practitioner (VMP) surgeon availability
- flow-on impact to elective lists and surgical outpatient clinics
- inpatient bed management/utilisation
- infection control precautions.

2.3 Scheduling "cold trauma" patients (beyond 48 hours)

Some patients may require pre-theatre management (i.e. "cold trauma" patients or gynaecological patients). Beyond 48 hours, the surgery is considered elective (refer to MP0169/21 Elective Services Access and Management Policy and WACHS Elective Surgery Waiting List Business Rules), and is to be booked as a Category 1 via the elective surgery wait list. However, these patients will not follow the usual elective surgery pre-admission pathway to prepare for surgery. The process for scheduling these surgeries is to be developed locally, however, an MR20 WACHS Request for Admission/Inclusion on Waiting List form is required. The patient must be booked as "elective" on the Theatre Management System (TMS). This is regardless of their admission status.

2.4 Booking emergency theatre cases

Following receipt of the completed booking slip, the process to be followed by the Theatre Coordinator (or after-hours delegate), is as follows:

- liaise with the surgical team to confirm the scheduled surgery date and time
- ensure post-operative care requirements have been identified and communicated (e.g. request an appropriate overnight bed or consider inter-hospital transfer following surgery)

- if the patient is not currently on the hospital premises, contact them to confirm the admission time, location and any relevant instructions (e.g. fasting).

2.5 Scope of clinical practice in emergency situations

Medical practitioners may work outside their usual scope of practice in emergency situations (where no other credentialed medical practitioner is available) to provide whatever clinical care is deemed necessary to preserve the health and life of a patient.

Authorisation is to be sought from the Regional Director of Medical Services as soon as reasonably possible (note that this step may be actioned retrospectively as per policy, Emergency Credentialing and Scope of Clinical Practice - Guidelines for reporting Emergency Situations to the Credentialing) Committee and the Emergency Situations – Credentialing Authorisation Form) which must be submitted to the Regional Director of Medical Services.

This does not replace the seeking of clinical advice from other specialist clinicians at the time (e.g. tertiary services or WACHS Clinical Director Surgery).

3. Roles and Responsibilities

The Regional Director of Medical Services is responsible for authorising a medical practitioner, in an emergency situation where no other credentialed medical practitioner is available, to provide whatever clinical care is deemed necessary to preserve the health and life of a patient. This authorisation may occur retrospectively after the emergency surgery has been completed.

The Consultant/Proceduralist (or their delegate) is responsible for assigning the relevant emergency surgery urgency category, completing the booking slip and collaborating with the Anaesthetist, Theatre Coordinator (or after-hours delegate) to schedule emergency cases appropriately. If the patient requires transfer pre- or postoperatively, they should liaise with Acute Patient Transport Coordination (APTC) and the receiving site team as appropriate.

The Anaesthetist is responsible for reviewing the patient as soon as possible to determine their risk for anaesthetic at the site, including post operative requirements. If post operative requirements exceed site capability this must be discussed with the Consultant/Proceduralist.

The Theatre Coordinator is responsible for receiving and actioning emergency surgery booking requests, collaborating with the surgical team to prioritise and schedule emergency cases and develop a plan for surgery ensuring appropriate staffing and availability of equipment.

The Executive on call is responsible for final arbitration in the event the local team cannot agree a clinical pathway.

All staff are required to comply with the directions in WACHS policies and procedures as per their roles and responsibilities. Guidelines are the recommended course of action for WACHS and staff are expected to use this information to guide practice. If staff are unsure which policies procedures and guidelines apply to their role or scope of practice, and/or

are unsure of the application of directions they should consult their manager in the first instance.

4. Monitoring and Evaluation

Using established site/regional governance processes, the effectiveness of this procedure will be monitored through the ongoing review of:

- WA Health Service Performance Report (HSPR) Emergency Surgery Urgency Category timeframe indicators P2-23a,b,c and d
- After hour staff recall and overtime data/trends
- Clinical incidents (clinical case review)
- Patient complaints
- Safety risk reports.

Clinical incidents are to be reported via Datix CIMS (refer to MP0122/19 Clinical Incident Management Policy 2019).

This procedure will be reviewed as required to confirm its effectiveness, relevance and currency.

5. References

Agency for Clinical Innovation. 2021. *NSW Emergency Surgery Guidelines and Principles for Improvement*. Sydney, New South Wales: New South Wales Government.

Armadale Kalamunda Group. 2021. *Emergency Surgery Theatre Bookings Procedure*. Perth, Western Australia: East Metropolitan Health Service.

Australian Institute of Health and Welfare (AIHW). n.d. *Elective Surgery*. METEOR identifier 568780. Canberra, Australian Capital Territory: AIHW.

Australian Institute of Health and Welfare (AIHW). n.d. *Emergency Surgery*. METEOR identifier 534125. Canberra, Australian Capital Territory: AIHW.

Healthcare Improvement Unit, Clinical Excellence Division. 2017. *Emergency Surgery Access Guideline*. Queensland: Queensland Department of Health.

South Metropolitan Health Service (SMHS). 2020. *Credentialing and Defining the Scope of Clinical Practice for Medical, Dental, Nursing and Midwifery Practitioners and Allied Health and Health Science Professions Policy*. Perth, Western Australia: SMHS.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). 2019. *Categorisation of urgency for caesarean section*. Melbourne, Victoria: RANZCOG.

West Australian Department of Health. 2017. *WA Emergency Surgery Urgency Categories*. Perth, Western Australia: Government of Western Australia.

Women and Newborn Health Service. 2023. Caesarean birth Clinical Practice Guideline. Perth, Western Australia: North Metropolitan Health Service (NMHS).

6. Definitions

Term	Definition
Cold trauma	Cold trauma is a surgical management of a patient that occurs at a later time after the initial injury.
Elective surgery	“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.” (AIHW METEOR ID - 568780)
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).” (AIHW METEOR ID - 534125)
Scope of clinical practice	“The extent of an individual practitioner’s approved clinical practice within a particular organisation based on an individual’s credentials, competence, performance and professional suitability and the needs and capability of the organisation to support the practitioner’s scope of clinical practice.” (SMHS 2020)
Surgical team	The surgical team consists of the Surgeon, Junior Doctors, Anaesthetist and theatre team. For obstetric cases, this would include the Obstetrician.
Theatre team	The theatre team consists of the Anaesthetic Nurse/ Technician, Scrub Nurse, Circulating Nurse and Recovery Nurse.
WA Emergency Surgery Urgency Categories	A set of five categories used to classify the urgency of emergency surgeries in Western Australia (WA), with associated timeframes. Available from WA Emergency Surgery Urgency Categories.

7. Document Summary

Coverage	WACHS-wide
Audience	All staff involved in scheduling, booking or providing care for patients undergoing emergency surgery
Records Management	Health Record Management Policy
Related Legislation	• *Health Services Act 2016* (WA)
Related Mandatory Policies / Frameworks	• MP0095/18 Clinical Handover Policy • MP0715/22 Consent to Treatment Policy • MP0084/18 Credentialing and Defining the Scope of Clinical Practice Policy • MP0169/21 Elective Services Access and Management Policy • Credentialing and Defining Scope of Clinical Practice for Medical Practitioners Standard
Related WACHS Policy Documents	• Management of Elective Surgical Patients with a High Body Mass Index Procedure • Patient Identification Policy
Other Related Documents	• Emergency Credentialing and Scope of Clinical Practice - Guidelines for reporting Emergency Situations to the Credentialing Committee • Emergency Situations – Credentialing Authorisation Form
Related Forms	• Emergency Surgery Booking Slip • MR20 Request for Admission/Waitlist Inclusion Form
Related Training Packages	Nil
Aboriginal Health Impact Statement Declaration (ISD)	ISD Record ID: 3627
National Safety and Quality Health Service (NSQHS) Standards	1.27, 6.09
Aged Care Quality Standards	Nil
Chief Psychiatrist's Standards for Clinical Care	Nil

8. Document Control

Version	Published date	Current from	Summary of changes
1.00	03 December 2024	03 December 2024	New Procedure

9. Approval

Policy Owner	Executive Director Nursing and Midwifery
Co-approver	Executive Director Clinical Excellence Executive Director Medical Services
Contact	Coordinator of Nursing – Perioperative
Business Unit	Nursing and Midwifery – Surgical Services
EDRMS #	ED-CO-24-350244

This document can be made available in alternative formats on request.

Appendix A: WA Emergency Surgery Urgency Categories

Category	Time	Description	Example procedures
EC1	<15 minutes	Immediate life, limb or organ-saving intervention. Resuscitation simultaneous with surgical intervention. Normally within minutes of decision to operate. The patient has immediate life-threatening condition or is shocked or moribund. Appropriate resuscitation is not providing the expected physiological response.	• Repair of ruptured aortic aneurysm • Laparotomy/thoracotomy for control of major haemorrhage (life, limb or organ threatening) • Craniotomy for life-threatening high ICP • Clot retrieval for strokes
EC2	< 2 hours	Serious condition requiring imminent treatment. Resuscitation simultaneous with surgical treatment. The patient has a life, limb or organ-threatening condition but is responding to resuscitative measures.	• Major trauma • Leaking aortic aneurysm (immediate treatment) • Laparotomy for perforation • Gastrointestinal bleeding • Sepsis with impending organ failure • Coronary angioplasty • Testicular torsion • Fasciotomy
EC3	< 6 hours	Operation not required immediately but must take place as soon as possible. The patient is physiologically stable but problem may undergo significant deterioration if left untreated.	• Intra-abdominal sepsis • Debridement plus fixation of open/complex fractures • Acute ischemic limb • Dental abscess/deep neck infection
EC4	< 24 hours	Operation as soon as possible after resuscitation. The patient is physiologically stable, but some risk of deterioration if left overnight.	• Irreducible hernia • Intestinal obstruction • Major fractures
EC5	< 48 hours	Time critical surgery. The patient's condition is stable.	• Required to maximise functional recovery

Source: West Australian Department of Health. 2017. WA Emergency Surgery Urgency Categories. Perth, Western Australia: Government of Western Australia.

Appendix B: RANZCOG Emergency Caesarean Section Urgency Categories

RANZCOG Category	Timeframe	Description	Example procedures
1	Within 30 minutes	Urgent threat to the life or the health of a woman or fetus.	Placental abruption Fetal distress
2	Within 60 minutes	Maternal or fetal compromise but not immediately life threatening.	Failure to progress
3		Needing earlier than planned delivery but without currently evident maternal or fetal compromise.	-
4		At a time acceptable to both the woman and the caesarean team, understanding that this can be affected by a number of factors.	-

Source: Adapted from The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). 2019. Categorisation of urgency for caesarean section. Melbourne, Victoria: RANZCOG.

NOTE: in alignment with the Women and Newborn Health Service (WNHS) Caesarean birth Clinical Practice Guideline, optimal decision to delivery interval (DDI) timeframes have been included for the categories where there is maternal or fetal compromise, although it is acknowledged that RANZCOG recommends that each case should be managed according to the clinical evidence of urgency, with every single case being considered on its merits (rather than attaching a specific time interval to each category).