Pre and Post Procedural Management Clinical Practice Standard

1. Purpose

The purpose of this policy is to establish minimum practice standards for the care and management immediately prior to, and following a procedure throughout the WA Country Health Service (WACHS).

This Clinical Practice Standard covers pre procedure care up to the handover of a patient to theatre/procedure unit and post procedure care from the handover of the patient by theatre/procedure unit to ward staff for the first 24 hours post procedure or discharge of patient (if earlier than 24 hours).

Removing unwanted variation in clinical practice and following best practice guidelines has been found to reduce inappropriate care (overuse, misuse and underuse) thus improving health outcomes, reducing preventable harm and decreasing wastage.

This policy is to be used in conjunction with WACHS Theatres Clinical Practice Standard.

Further information relating to specialty areas including Child and Adolescent Health Service (CAHS), Women and Newborn Health Services (WHNS) can be found via HealthPoint if not covered in this policy.

2. Scope

All medical, nursing, midwifery and allied health staff employed within the WACHS.

All health care professionals are to work within their scope of practice appropriate to their level of training and responsibility.

Further information may be found via HealthPoint or the Australian Health Practitioner Regulation Agency as appropriate.

3. Procedural Information

Refer to the following procedures within this document:

- Appendix 1: Pre-Procedure Care Procedure
- Appendix 2: Post Procedure Care Procedure

Consent to treatment must be obtained prior to commencement of procedure.
WA Health OD 0657/16 WA Health Consent to Treatment Policy

Where care requires specific procedures that may vary in practice across sites, staff are to seek senior clinician advice.

4. General Information

Within WACHS a variety of procedures are undertaken within operating theatres/day procedure units to address an array of clinical conditions, where specific pre or post procedure care is required refer to patient's health record and procedure specific information.

5. Patient Monitoring

An individualised management plan is to be documented in the patient's health records as soon as practicable, and in relation to the specific requirements for clinical risk prevention and management. At a minimum, the plan must consider:

- procedure performed and any specific observations required
- documented pre and post procedure treatment plans
- patient history and presence of comorbidities
- diagnosis and treatments for clinical conditions
- medications, psychosocial and cultural factors that could influence patient monitoring
- frequency and type of specific observations
- patient education and consent e.g. any restrictions to interventions associated with advance health directives (AHD) or similar.
- Refer to NSQHS Standard 9: Recognising and responding to clinical deterioration in acute health care.

6. Clinical Communication

Clinical Handover

Information exchange is to adhere to the WA Health OD 0484/14 Clinical Handover Policy using the iSoBAR framework.

Critical Information

Critical information, concerns or risks about a consumer are communicated in a timely manner to clinicians who can make decisions about the care.

Documentation

Failure to accurately and legibly record and understand what is recorded in patient health records contribute to a decrease in the quality and safety of patient care.

Refer to WACHS Documentation Clinical Practice Standard.

Consumer information

There are a number of ways consumers can obtain specific information relating to hospital admissions, transfers and discharge from hospital. Relevant documents can be located via:

- Procedure Specific Information Sheets (PSIS).
- Patient Medicines Information.
- Information leaflets for patients about medicines used in mental health.
- Emergency Discharge Information Sheet, WA Health.

7. Compliance

Evaluation, audit and feedback processes are to be in place to monitor compliance.

Failure to comply with this policy may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Employment Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (HSA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

8. Legislation

(Accessible via: Government of Western Australia (State Law Publisher or ComLaw))

- *Carers Recognition Act 2004*
- *Children and Community Services Act 2004*
- *Civil Liability Act 2002*
- *Disability Services Act 1993*
- *Guardianship and Administration Act 1990*
- *Health Practitioner Regulation National Law (WA) Act 2010*
- *Human Tissue and Transplant Act 1982*
- *Mental Health Act 2014*
- *Occupational Safety and Health Act 1984*
- *Occupational Safety and Health Regulations 1996*
- *Pharmacy Act 1964*
- *Poisons Act 1964*
- *Poisons Regulations 1965*
- *Privacy Act 1988*
- *State Records Act 2000*

9. Standards

National Safety and Quality Health Services (NSQHS) Standards

- NSQHS Edition 1Standards 1.8.3, 5.4.1, 5.5.1, 6.2.1, 9.4.1, 9.5.1
- NSQHS Edition 2 Standards 6.5, 6.6, 6.8, 8.2, 8.8

10. Related WA Health System Policies

Clinical Alert (Med Alert) Policy
Clinical Deterioration Policy
Clinical Handover Policy
Clinical Incident Management Policy
Consent to Treatment Policy
Correct Patient, Correct Site and Correct Procedure Policy and Guideline for WA Health Services (2nd Edition)
Patient Identification Policy 2014

11. Related Policy Documents

Theatres - Clinical Practice Standard
Clinical Observations and Assessments Clinical Practice Standard
Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard
Diabetes - Inpatient Management - WACHS Clinical Practice Standard
Colonoscopy Clinical Practice Standard
Imaging - WACHS Clinical Practice Standard

12. Policy Framework

Clinical Governance, Safety and Quality Policy Framework.

13. Acknowledgement

Acknowledgment is made of the previous SMHS / WACHS site endorsed work used to compile this Pre and Post Procedural Management Clinical Practice Standard.

14. Definitions

Carer	Carers provide unpaid care and support to family members and friends who have a disability, mental illness, chronic condition, terminal illness, an alcohol or other drug issue or who are frail aged (Carers Australia, 2015).
Patient	A person who is receiving care in a health service organisation.
Procedure	For the purpose of this CPS the term procedure will refer to all invasive/non-invasive procedures that require specific actions pre and immediate post that procedure.

This document can be made available in alternative formats on request for a person with a disability

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15. Appendix 1 - Pre-Procedure Care

Pre-procedure care is undertaken to assess and prepare a patient physically and psychologically prior to the undertaking of a procedure to identify potential problems, minimise post procedure/surgery complications and ensure the patient is fully informed.

It is the responsibility of the Medical Officer (MO) to obtain procedural consent, complete the appropriate consent form and document in the patient's health care record. The MO should fully inform the patient of the potential risks of medical or surgical procedures invasive to the body.

Prior to any procedure being undertaken appropriate patient education must be completed to ensure understanding of the procedure to be carried out. Where possible, patients are to be provided with procedure specific information such as the preferred Procedure Specific Information Sheets (PSIS). Should the patient require further information or education health care staff is to liaise with MO/senior clinician.

For non-elective cases (emergency and/or urgent cases), pre procedure care is to be prioritised according to the patients clinical condition, time constraints and specific instructions from MO/senior clinician.

Procedure	Action
Pre-Procedure Checklist	Completion of specific pre procedure checklist(s) that include: • Patient identification label is applied and correct. • Patient consent present and complete. • Relevant site has been identified and marked by the surgeon or their delegate. • Baseline observations are undertaken and documented. • Administration of pre-medication as prescribed in patient's medication chart. • Remove nail polish and jewellery, if present. • Remove, label and store prosthesis/aids (dentures, glasses, contact lenses, hearing aids) as appropriate.
Fasting	• Refer to procedure specific diet and fluid restriction requirements and undertake as required for patient's clinical condition, procedure being undertaken or instruction from MO/senior clinician.
Physiological Observations Refer to Clinical Observations and Assessments CPS (physiological, neurovascular, neurological and fluid balance).	• Observations can vary according to the patient's clinical condition and procedure being undertaken. • Baseline physiological observations must be performed as a minimum requirement pre procedure. • Other observations requested by MO/senior clinician. • Day procedure units must complete and record baseline observations on the day of the patients admission for procedure and pre-procedure.

Blood Glucose Level (as appropriate) Refer to Diabetes - Inpatient Management Clinical Practice Standard	• All patients with Diabetes are to be assessed by MO/senior clinician prior to procedures that require fasting. • All patients with Diabetes are to have blood glucose level (BGL) documented 1-2 hours prior to surgery or more frequently as clinically indicated.
Medication Refer to Medication Administration Policy	• Administer medications as prescribed on the medication chart unless otherwise instructed by MO/senior clinician. • **NOTE:** Pre-medication is to be withheld if consent has not been completed.
Venous Thromboembolic Management Refer to Venous Thromboembolism Prevention Clinical Practice Standard	• All adult patients on admission are to have a risk assessment for Venous Thromboembolism (VTE) documented and a prophylaxis plan determined. • Ward health care staff must advise theatre/procedure unit staff on handover and document in the patient's health care record and medication chart if prophylactic VTE medications and/or devices have not been administered/ initiated as prescribed by MO/senior clinician.
Skin Preparation	• Refer to procedure specific/surgeon requirements for hair removal. • Procedure/surgical site hair is to be removed with clippers or depilatory cream. **Do not** shave the site. • Pre-operative showers are recommended to reduce microbial colony counts; however they have not definitively been shown to reduce surgical site infection rates.
Bladder Management Refer to Bladder Management Continence Clinical Practice Standard	• Encourage the patient to void prior to administering pre-procedure medication and/or leaving for the procedure. Document time of last void on relevant pre-procedure checklist. • Perform urinalysis on all patients who have not had this completed within 24 hours of admission/prior to procedure/surgery.
Bowel Management Refer to Bowel Management Clinical Practice Standard	• As per procedure specific requirements or MO/senior clinician documented instruction.

The member of staff escorting the patient to/from procedure room/theatre must have the appropriate level of expertise to manage both the level of patient acuity and any equipment required during the transfer. Refer to the WACHS Admission, Discharge and Intra-hospital Transfer Clinical Practice Standard.

16. Appendix 2 - Post-Procedure Care

Post procedure care is undertaken to reduce the risk of complications for the patient post procedure/surgery. Prior to collecting patients from post-procedure areas, ensure all bedside equipment has been checked and is in working order

Procedure	Action
Clinical Handover	• Patients must meet the recovery room discharge criteria for handover to take place and transfer back to the ward/clinical area. Refer to Theatres Clinical Practice Standard • Handover must be undertaken by appropriate clinical staff and can be either verbal or written but as a minimum is to include: ▪ name of patient ▪ procedure performed (including any adverse events) ▪ relevant medical and surgical history including allergies ▪ physiological /Clinical Observations ▪ post procedure instructions/parameters ▪ post-operative nausea and vomiting (PONV) is addressed and anti-emetics are prescribed) ▪ all medications administered ▪ pain management plan in place, analgesia last administered and effect ▪ wound status and/or drain status ▪ invasive access devices (venous access, indwelling catheters) ▪ fluids and/or medications infusing urine output. • Receiving Nurse/Midwife is to confirm: ▪ patient is able to respond to verbal stimuli (comparative to pre-procedure) ▪ the last set/discharge from recovery physiological observations have been documented on the observation and response chart (ORC). Observations in the Senior Nurse Review or Increased Surveillance zones may be accepted for transfer from Recovery to the ward, without a modification. Inform Shift Coordinator on return to ward. Monitor during the first 2 hour period and escalate to MO/Shift Coordinator of any concerns ▪ all wound sites and drains for type, patency and drainage volumes; ensure dressings are intact. There should be no excessive loss from drains or wounds. If the Recovery Room Nurse is unsure of bleeding origin, the Surgeon/Anaesthetist is to review the patient prior to leaving the area ▪ all equipment, drains, catheters, tubes and IV attachments are secure continued…….

Clinical Handover Continued……	• Receiving Nurse/Midwife is to confirm: ▪ if the receiving Nurse/Midwife determines that the patient may not be suitable for transfer they must express their concern with recovery nursing staff and escalate as required to, recovery coordinator and/or contact the ward/unit Shift Coordinator and request review ▪ all documentation and patient belongings (dentures, hearing aids) accompany patient to the ward.
On return to the ward/clinical area	• Perform and document physiological and any specific observations including oxygen therapy on the ORC. • Perform post-procedure assessment and consider: ▪ wounds ▪ dressings ▪ drains ▪ skin temperature and colour ▪ ensure the patient is warm and comfortable using appropriate resources ▪ IV fluids and check settings against the prescribed orders ▪ bladder management ▪ pain management and analgesic techniques.
Oxygen Therapy Refer to Oxygen Therapy – Adults Clinical Practice Standard	• Administer oxygen as prescribed and patient requirements. • If the patient's oxygen requirements are increasing, at any stage, the Shift Coordinator/MO should be informed **immediately.**
Post-Operative Nausea and Vomiting (PONV)	• A choice of anti-emetics is to be prescribed by the MO/senior clinician on the patient's medication chart in the "as required medications PRN" section. • Anti-emetics are to be administered as prescribed and the patient assessed for effectiveness. The MO/senior clinician is to be informed if PONV persists.
Observations Refer to Clinical Observations and Assessments CPS (physiological, neurovascular, neurological and fluid balance)	• Observations include physiological observations plus any other measures as indicated by the patient's clinical condition or nature of surgical procedure for example: ▪ neurovascular status ▪ wound drainage ▪ blood glucose levels ▪ sedation score ▪ sensory level and motor (Bromage) score if an epidural or regional infusion in situ. Refer to Epidural/Spinal Analgesia Management Policy.

Observations Continued…… Refer to Clinical Observations and Assessments CPS (physiological, neurovascular, neurological and fluid balance)	• Frequency of monitoring is to be increased if abnormal values are observed, activate Medical Emergency Response (MER) as clinically indicated. Refer to Clinical Escalation Including Medical Emergency Response (MER) Policy. • The patient's observations are to (at a minimum) be monitored and documented using the following frequency protocol and clinical judgement: ▪ on return to the ward ▪ ½ hourly x 2 hours ▪ 1 hourly x 2 hours ▪ 2 hourly x 2 hours ▪ 4 hourly thereafter. • If a patient has had an extended time in a post-procedure area and observations have been performed – these observation time frames are to be included as part of the frequency protocol unless otherwise instructed.
Blood Glucose Level Refer to Diabetes - Inpatient Management Clinical Practice Standard	• As per specific patient requirements or MO/senior clinician documented instruction.
Pain Management	• Perform and document Pain Assessment as appropriate. • Administer pain medication as prescribed.
Bladder Management Refer to Bladder Management Continence Clinical Practice Standard and Bladder Management Urinary Catheters Clinical Practice Standard	• If a urinary catheter is in-situ ward, monitor and manage as per post procedure instructions or as clinically indicated. • Maintain a fluid balance chart as per specific requirements or as clinically indicated. • Assess for urinary retention and/or risk of bladder distension injury. • If a patient has not voided 4-6 hours from documented pre-procedure time of last void or 2 hours after return to the ward (whichever is earliest): ▪ encourage patient to void ▪ consider fluid status of the patient and fluid input during procedure ▪ consider performing bladder scan, liaise with shift coordinator. • Notify Shift coordinator/MO for ongoing management plan if clinically indicated.

Venous Thromboembolic Management Refer to Venous Thromboembolism Prevention Clinical Practice Standard	• Recovery staff must advise ward health care staff on handover if prophylactic VTE medications and/or devices have not been administered as prescribed by MO/senior clinician.
Wound Management Refer to Impaired Skin Integrity Clinical Practice Standard	• Wound management is to be carried out in accordance with specific requirements or MO/senior clinician documented instruction.
Hygiene	• Within 4 hours of returning to the ward the patient is to be offered the opportunity and/or assistance to: ▪ wash and freshen up to remove any surgical preparation/antiseptics ▪ perform oral hygiene ▪ remove soiled clothing/bed linen changed. • Surgical incision wounds are to remain intact for the first 24-48 hours (procedure dependent). Cover with a waterproof dressing prior to showering. • If a wound can be exposed prior to 48 hours post-procedure and it is clean and dry the patient can shower and pat dry the area with a clean towel.