

Clinical Guidelines for Pre-Assessment

Document Reference No:	PTHB / TEP 020	
Version No:	6	
Issue Date:	September 2022	
Review Date:	March 2024	
Author:	Theatre Management Team	
Document Owner:	Theatre User Group	
Accountable Executive:	Executive Director for Primary Care, Community and Mental Health Services	
Approved By:	Executive Director for Primary Care, Community and Mental Health Services	
Approval Date:	2/09/2022	
Document Type:	Guidelines	Clinical
Scope:	Surgical Services	

The latest approved version of this document is online.
If the review date has passed, please contact the Author for advice.

PTHB Teaching Health Board is the operational name of PTHB Teaching Local Health Board
Bwrdd Iechyd Addysgu PTHB yw enw gweithredol Bwrdd Iechyd Lleol Addysgu PTHB

Version Control:

Version	Summary of Changes/Amendments	Issue Date
1	Initial Issue	JUNE 2003
2	Reviewed	OCT 2007
3	Reviewed and updated in line with The Association of Consultant anaesthetists of Great Britain & Ireland. January 2010: Pre-Operative Assessment & Patient Preparation. The Role of the Consultant anaesthetist 2	JAN 2011
4	Reviewed	DEC 2013
5	Reviewed, amended from policy to guidelines and changed title	APR 2021
6	Added Section 24 Supporting Early Recognition & Management of Adrenal Crisis in Adults Following PSN 057	APR 2022

Engagement & Consultation

Key Individuals/Groups Involved in Developing this Document

Role / Designation
Theatre Management
PTHB Clinical Leads for Anaesthetics

Circulated to the following for Consultation

Date	Role / Designation
17.01.14	Theatre User & Audit Group
17.01.14	Theatre Manager
17.01.14	Unit Meeting
OCT 2019	Theatre Management
DEC 2019	PTHB Clinical Leads for Anaesthetics
APR 2021	Theatre User Group
FEB 2022	PTHB Clinical Lead for Anaesthetic
APR 2022	Theatre User Group

Item No.	Contents	Page
1	Introduction	5
2	Objectives	5
3	Abbreviations	6
4	Role / Responsibilities	6
4.1	Consultant Anaesthetist Clinical Lead	6
4.2	Medical Director	7
4.3	Senior Nurse Manager for Theatres & Endoscopy	7
4.4	Theatre & Endoscopy Co-ordinator / Team Leader	7
4.5	PAS Nurses	7
4.6	All Other Staff Relating to the Pre-anaesthetic Screening Process	8
5	Process	8
5.1	When Should Pre-operative Assessment Take Place	8
5.2	Where Pre-operative Assessment Will Take Place	8
5.3	Who Should Perform Pre-operative Assessment	8
6	Pre-Assessment Timescale	9
6.1	Day Surgery within Six Months of Pre-operative Assessment	9
6.2	Day Surgery more than Six Months after Pre-operative Assessment	9
7	Information to be Given to Patients	9
7.1	Post-operative Flying Advice	10
8	How Records Should be Kept	10
9	Guidelines for Selecting Patients for Day Surgery	11
10	Social Parameters	11
11	Age	12
12	General Health	12
13	Weight	13
14	Specific Organ Systems and Diseases	13
14.1	Respiratory System	13
14.2	Cardiovascular System	14
14.3	Endocrine System	16
14.4	Renal System	16
14.5	Liver Disease	16
14.6	Neurological System	16
14.7	Gastrointestinal system	16
15	Mentally Unwell Patients & Patients with Learning Difficulties	17
16	Pregnancy	17
17	Latex Allergy	17
18	Drug History	17
19	Anaesthetic	18
19.1	Anaesthetic History	18
19.2	Airway assessment	18
19.3	Thromboprophylaxis Assessment	19
20	Guidelines for Pre-operative Investigations	19

20.1	Principles	19
20.2	Investigations	19
21	Fasting Guidelines	22
22	Psychological Parameters	22
23	Assessment of Carers	22
24	Supporting Early Recognition & Management of Adrenal Crisis in Adults	23
25	Monitoring Compliance / Audit	23
26	Review and Change Control	25
27	References / Bibliography	26
	Appendices	
A	Normal Peak Expiration Flow (PEF)	27
B	Unfit for Surgery Letter to Consultant / Currently Unfit for Surgery Letter to GP	28
C	Alcohol Dependency Tool	30
D	Pre Assessment Flow Charts	34

1. Introduction

These guidelines cover routine pre-operative tests for people aged over 18 who are having elective surgery but it does not cover pregnant women. It aims to reduce unnecessary testing by advising which tests to offer people before minor and intermediate surgery performed in PTHB.

Pre-operative assessment establishes that a patient is fully informed and wishes to undergo the procedure. It ensures that the patient is fit for the surgery and anaesthetic. It minimises the risk of late cancellations by ensuring that all essential resources and discharges requirements are identified.

Patient assessment prior to admission for elective surgery in other fields has been reported to show a reduction in cancellations on the day of surgery. Patients should be fully informed about their operation and fit for surgery on the agreed date. Implementing pre-operative assessment should improve the patient's experience of surgery, by providing information about the operation and giving patients the opportunity to ask questions.

2. Objectives

Pre-operative assessment is fundamental to the patient's surgical pathway. It ensures that the patient is fully informed about the risks and benefits of surgery and that the patient is fit for surgery and anaesthetic. It reduces the risk of late cancellations by ensuring that all essential resources are available and facilitates the discharge planning. In PTHB, we only undertake patients that are ASA1 and ASA2 due to our community settings.

To ensure there is a system in place that minimises any risks of surgery & anaesthesia in order to ensure the best possible outcome for the patient.

- Assess the patient's fitness for surgery and anaesthesia, including the risks of the combined effects of surgery and anaesthesia.
- Provide the opportunity for explanation and discussion to minimize any fears or anxiety the patient may experience.
- Provide information about the pre-operative process and any specific pre-operative instructions, e.g. who to contact if they want to cancel the operation, any fasting instructions.
- Identify any special requirements for the surgical procedure.
- Identify any cultural requirements, and any communication or other special needs.
- Assess the home support available to the patient post-discharge and identify any special requirements to facilitate prompt discharge.

- Reduction in postponement of the patient’s surgery due to the patient being unfit, as there has been adequate time for investigations to be carried out and actions taken prior surgery.

3. Abbreviations

PTHB	Powys Teaching Health Board
ASA	The American Society of Anesthesiologists
AAGBI	The Association of Anaesthetists of Great Britain and Ireland
ECG	Electrocardiogram
PAS	Pre-Anaesthetic Screening
WG	Welsh Government
LA	Local Anaesthetic
GA	General Anaesthetic
BMI	Body Mass Index
COPD	Chronic Obstructive Pulmonary Disease
OSA	Obstructive Sleep Apnoea
DGH	District General Hospital
MI	Myocardial Infarction
CVA	Cerebrovascular Accident
TIA	Transient Ischaemic Attack
CAPD	chronic ambulatory peritoneal dialysis
NIDDM	Non-insulin Dependent Diabetes Mellitus
HbA1c or Hb	Hemoglobin A1c or Hemoglobin
HRT	Hormone Replacement Therapy
FBC	Full Blood Count
U&E	Urea and Electrolytes
NICE	National Institute for Clinical Excellence
AfPP	Association for Peri-operative Practice

4. Role / Responsibilities

4.1 Clinical Lead Consultant Anaesthetist

- The consultant anaesthetist clinical lead supports guidance for assessors to refer patients not currently suitable for day surgery (due to commonly occurring conditions such as hypertension) to other health care professionals.
- Be available to allow discussion of any patient with complex needs. Any consultant anaesthetist supporting the pre-operative assessment service should be a consultant or non-consultant career grade doctor with day surgery experience.

	<ul style="list-style-type: none">• Refer any complex patients needing investigations and treatment to the relevant consultant or department, if guidelines do not exist for the assessor to do this.
	4.2 Medical Director <ul style="list-style-type: none">• To be kept updated with current policies and practices
	4.3 Senior Nurse Manager for Theatres & Endoscopy Senior Nurse Manager for Theatres & Endoscopy must: <ul style="list-style-type: none">• Ensure all staff read and understand this protocol• Arrange review to monitor compliance with this protocol
	4.4 Theatre & Endoscopy Co-ordinator / Team Leader They must: <ul style="list-style-type: none">• To give help and advice to all staff members on this process• Develop and deliver training in line with this protocol
	4.5 PAS Nurses <ul style="list-style-type: none">• Work to guidelines and competencies agreed by the day surgery consultant anaesthetists and consultant surgeons to ensure a consistent approach.• Refer patients who fall outside the agreed criteria to a consultant anaesthetist.• Refer a patient back to the care of their general practitioner (GP) or another healthcare professional where this is needed to optimise the patient's medical condition, according to local guidelines. Appendix B• Ensure that the results are obtained and, if a referral or further investigation is required before surgery, discussed with the consultant anaesthetist/surgeon and patient.• Refer abnormal investigation results to an appropriate consultant anaesthetist according to local guidelines. Unless specific training has been given, all ECGs will need to be screened by a consultant anaesthetist.• Take responsibility for all communication with the patient throughout the patient's pre-operative journey. This includes checking the results of all

	<p>investigations and ensuring that any abnormal results are acted upon to avoid later cancellations.</p> <ul style="list-style-type: none"> Refer any patients who are optimally treated, but unsuitable for day surgery, to the surgeon's inpatient waiting list, notifying the surgeon. <p>Appendix B</p>
	<p>4.6 All Other Staff Relating to the Pre-anaesthetic Screening Process</p> <p>All staff working within the Day Surgery Unit that are involved with the pre-anaesthetic screening process, should:</p> <ul style="list-style-type: none"> Ensure that they have received the necessary in service training Have completed the required competencies. Be aware of the pre-anaesthetic screening guidelines
<p>5. Process</p>	
	<p>5.1 When Should Pre-operative Assessment Take Place</p> <p>The first process at PTHB is to undertake the screening questionnaire, this will then determine if they need face-to-face assessment or telephone assessments with PAS nurses at band 5 or with consultant anaesthetic review as we currently do not have a pre-assessment team.</p> <p>Early pre-operative screening reduces the perioperative workload of the consultant anaesthetist as patients should arrive for surgery fit and informed, having been appropriately investigated. The patient should be given a reasonable estimate of the time needed for the pre-operative assessment appointment and be offered a choice of dates.</p>
	<p>5.2 Where Pre-operative Assessment Will Take Place</p> <p>Consulting and examination rooms equipped with blood pressure monitors, electrocardiogram machine, phlebotomy services, etc. should be available to allow full pre-operative assessment to be performed. To reduce waits and delays for patients, investigations should wherever possible, be performed by the pre-operative assessor. Patients awaiting pre-operative assessment should be separated from those patients recovering from surgery.</p>
	<p>5.3 Who Should Perform Pre-operative Assessment</p> <p>A trained and competent pre-operative assessor should perform pre-operative assessments. The pre-operative assessor should be able to order, perform basic investigations and make referrals according to guidelines agreed locally by the</p>

clinical lead for anaesthetics and consultant surgeon involved. Although some patients will need additional assessment by a consultant anaesthetist to determine their suitability for day surgery, many patients will not need to see a consultant anaesthetist until the day of operation.

The consultant anaesthetist giving the anaesthetic is ultimately responsible for the decision to proceed, but if all day surgery consultant anaesthetists work within the agreed guidelines, the number of cancellations on the day will be negligible.

6. Pre-Assessment Timescale

6.1 Day Surgery within Six Months of Pre-operative Assessment

Following pre-operative assessment, and providing the patient is suitable for surgery, a date for surgery can be agreed and booked with the patient. Patients should be asked to inform the theatre administrators if:

- They want to change the date
- They have a significant illness requiring hospital admission or a new treatment.
- There is a change in their medication.
- They have a minor illness that will not resolve by the date of surgery.

6.2 Day Surgery more than Six Months after Pre-operative Assessment

To minimize cancellation by the patient and to identify further investigations and treatment the patient must be contacted before the expected operation date to:

- Check that there is no alteration in medical and social circumstances
- Agree a date to attend for investigations if required.
- Confirm the final date
- Repeat any pre-operative instructions

7. Information to be Given to Patients

The following information is given during the patients assessment:

- The procedure to be performed.
- Fasting times and other pre-operative preparation.
- Degree of discomfort anticipated and how the pain will be relieved.
- Any adverse symptoms that may occur and what to do.
- Approximate time needed off work to be advised by the surgeon.

- When it will be safe to resume driving and other normal activities.
- What to bring on the day of admission, e.g. medication.
- Whether or not relatives can accompany them.

7.1 Post-operative Flying Advice

Each airline has its own regulations about flying after surgery. Therefore, the patient will need to ensure that they check with their airline before they fly, particularly if they have had complicated surgery.

It is advised that you they their travel insurance policy carefully, as they may need to inform the insurance company that they have recently had surgery. This could also increase the cost of their travel insurance.

Type of surgery – under a general anaesthetic	Travel allowed after	Requirements
Minor /Investigative procedure/Surgery Examples include: hysteroscopy, tooth extraction, endometrial ablation, excision of breast lump etc.	1-2 weeks Depending on your recovery and any pre or postoperative conditions, which may pose a risk.	If travelling before 6 weeks of surgery, you will need to: <ul style="list-style-type: none"> • Check with your insurance company to see if you are covered to travel after your operation. • Check with your airline to see if you need a written confirmation from your Doctor of fitness.
Intermediate surgery Examples include: hernia repair, tonsillectomy, laparoscopic cholecystectomy (Gall bladder removal), anterior/ posterior repair etc.	2-3 weeks Depending on your recovery and any pre or postoperative conditions, which may pose a risk.	

8. How Records Should be Kept

The patient’s medical record must be available at pre-operative assessment to obtain the previous medical history and fill in appropriate records. A standardised method of recording information from the pre-operative assessment should be used. A single multi-disciplinary record should be used to reduce duplication of questioning and records.

9. Guidelines for Selecting Patients for Day Surgery

Principles:

Most operations in the extended British Association of Day Surgery (BADs), Audit Commission and WG trolley of day surgery procedures should be included on a locally agreed list of day surgery procedures. Additional specialist procedures may be added to this list.

All patients having a procedure on the list of procedures suitable for day surgery should be assessed to ascertain their suitability for day surgery. If, after explanation of the advantages of day surgery, patients do not want to have their operation on a day surgery basis, their wishes should be respected. Patients are generally suitable for day surgery unless one or more of the contraindications apply. If one or more of the relative contraindications apply, advice should be sought from an appropriate consultant surgeon or consultant anaesthetist.

10. Social Parameters

Day surgery demands suitable home circumstances and ongoing care from responsible carers. There is no justification for discharging a patient to the care of someone who is unable to fulfil the role of carer due to ill health or infirmity, or to unsuitable home conditions. For this reason, it is essential at assessment the social criteria are addressed to ensure safety on returning home. Key aspects are:

- A. A responsible and physically able adult to look after them for 24 hours after the operation
- B. An escort to drive them home by private car or accompany them in a taxi
- C. Access to a telephone (either at home or close by)
- D. Easy access to the home, or place of care, with an indoor toilet
- E. GP/Nursing Practitioner backup available

If patients have not been made aware of the above criteria prior to surgery, it may result in overnight admission purely for social reasons. A fully informed patient is best placed to ensure that the social criteria's are met. It is advisable to inform patients that there may be prolonged effects from the general anaesthetics and therefore they should not drive, operate machinery, or sign important documents for 48 hours post operatively.

Most patients, if advised in advance, will be able to meet these requirements, but for others it may not be so practical, these patients will be referred for inpatient admission or to their relevant district hospital.

More than one hour of travelling time after surgery should be the maximum, although other considerations should be taken into account (e.g. nature of surgery, availability of medical assistance, etc.); some patients may wish to go home even if they live long distance away. They should understand the possibility of pain, nausea

and vomiting during prolonged journey and be prepared to accept this risk. This should be documented and discussed with the clinicians involved.

11. Age

When considering age it is worth remembering that the elderly may have other problems relating to the ageing process that may make day surgery non-viable.

We have no upper age limit in PTHB for LA or GA but we do not operate on anyone under GA under the age of 18. For LA we operate on from 16 years of age.

12. General Health

Patients who are assessed as ASA grade 1-2 are acceptable, any other ASA grades would need to be referred back to the consultant anaesthetist for an opinion, if deemed as 3, we would need to follow the procedure of refer back to consultant / surgeon.

Please see below for the **ASA physical status classification system** that we follow:

ASA PS Classification	Definition	Examples, including, but not limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Examples include, (but not limited to): hypothyroidism, current smoker, social alcohol drinker, pregnancy, obesity (>30 BMI < 40), well controlled diabetes, HTN, hypertension, mild lung disease
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to): poorly controlled diabetes or HTN, COPD, morbid obesity (BMI ≥40), hyperthyroidism, active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents

ASA IV	A patient with severe systemic disease that is a constant threat to life	Examples include (but not limited to): recent (< 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis
ASA V	A moribund patient who is not expected to survive without the operation	Examples include (but not limited to): ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes	

13. Weight

Obesity is a major consideration in day surgery. Obese patients are also susceptible to other medical conditions, e.g. hypertension, and there is an increased risk of complications; therefore, obese patients are generally excluded for day surgery.

In determining an acceptable limit, it may be necessary to consider the type of surgery being performed. The weight of a patient alone is not an ideal method of measuring obesity – height should also be taken into consideration. The Body Mass Index (BMI) takes into account of weight and height and is a more suitable indicator of obesity. Patients who are rejected because of weight problems may require help and advice.

Body Mass Index (BMI):

Patients with BMI of 35 or below are acceptable for day surgery within PTHB unless they have other contraindications. Patients that fall slightly over this criteria can be looked at as an individual basis with the clinical team and will need to be referred to the consultant anaesthetist clinical lead.

An absolute weight limit for local anaesthetic is based on the maximum weight the trolleys or operating tables will allow or by the local manual handling policy.

14. Specific Organ Systems and Diseases

14.1 Respiratory system

- Past history of COVID 19 does not exclude any patients from day surgery, however if a patient has had COVID 19 and still has dyspnoea grading 2,3

& 4 or other ongoing symptoms at pre-assessment they should be referred back to their GP until clinically all symptoms have resolved. Any patient who has had COVID 19 and is symptom free should have a peak flow test carried out at pre-assessment.

- Asthma, chronic obstructive pulmonary disease (COPD) and smoking do not exclude patients from day surgery provided they are well controlled. (Please see the attached peak flow chart Appendix A). Also, please note Mallampati class 3 or 4 will need to be referred to the consultant anaesthetist
- Smoking cessation should be encouraged in patients evaluated more than 4 weeks prior to surgery.

Contraindications:

- Chronic pulmonary disease with dyspnoea grading 3 & 4
- Patients with obstructive sleep apnoea (OSA) who are not receiving treatment and who are likely to require opioids to treat post-operative pain.

Relative contraindications:

- Patients with poorly controlled asthma e.g. needing oral steroids frequently or within last 3 months or frequent hospital admissions for exacerbation of asthma (**excluded from PTHB**).

Dyspnoea grading	
0	No dyspnoea while walking on level at normal pace.
1	Mild, non-specific (speed not distance) restriction. "Walk as far as I like provided I take my time."
2	Moderate, specific outdoor limitation. "Stop for a while after... (a recognisable distance limitation)."
3	Marked dyspnoea on mild, indoor exertion. "Stop for a while between kitchen and bathroom."
4	Incapacitation. Dyspnoea at rest.

14.2 Cardiovascular System

Contraindications:

- Myocardial infarction within last 6 months applicable to DGH's only. In PTHB we follow the set criteria for post MI patients:

A. We do not operate on any patients under GA post MI

B. If listed for a procedure under LA we would wait 12 months post MI and consider that sometimes clinical decisions could change on the day depending on any changes in the patient's condition

- Angina classification 3 & 4 (see New York Heart Association classification of Angina below).

Relative contraindications:

- Anticoagulant treatment - contact referring surgeon for advice. Some simple procedures can be undertaken.
- Cerebrovascular accident (CVA) or transient ischaemic attack (TIA) within 1 year. Discuss with consultant anaesthetist

Potentially treatable conditions:

Patients suffering from the conditions below may be suitable for day surgery after referral and treatment. Although they would be not suitable for surgery in PTHB:

- Untreated angina classification 2 (see New York Heart Association classification of Angina below)
- Uncontrolled or poorly controlled cardiac failure – not suitable for PTHB
- Orthopnoea (waking at night gasping for breath, unable to sleep flat) – not suitable for PTHB
- Blood pressure greater than 100mm Hg diastolic or systolic greater than 180mm Hg regardless of diastolic pressure. Surgery should be delayed until blood pressure is controlled and has been stable for about 4 weeks. It is important to explain to the patient the reasons for controlling blood pressure before operation.

New York Heart Association Classification of Angina:

Class I	Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea and/or angina
Class II	Ordinary physical activity does not cause undue fatigue, palpitations, dyspnea and/or angina
Class III	Less than ordinary physical activity causes undue fatigue, palpitations, dyspnea and/or angina
Class IV	Fatigue, palpitations, dyspnea and/or angina occur at rest

	<p>14.3 Endocrine System</p> <p>Well controlled diabetes mellitus is not <u>a contraindication</u>, but the nature of the planned procedure and post operative course needs to be taken into consideration, together with the patient's understanding of his/her diabetic control. Within PTHB for GA procedures we only operate on patients with diet or tablet controlled. For local procedures we do accept patients that are insulin controlled.</p> <p>Oral hypoglycaemic therapy (NIDDM):</p> <p>All diabetic patients should be instructed to discuss with their diabetic nurse and GP and ask patients to bring tablets with them.</p> <p>Every diabetic patients should take HbA1c test and refer to consultant anaesthetist</p>
	<p>14.4 Renal System</p> <p>Contraindications:</p> <p>Day surgery is generally not suitable for patients undergoing haemodialysis or chronic ambulatory peritoneal dialysis (CAPD) due to practical difficulties and to co-morbidity.</p>
	<p>14.5 Liver Disease</p> <p>Contraindications:</p> <ul style="list-style-type: none">• Patients with advanced liver disease are unsuitable for day surgery.• Some simple procedures may be possible in patients with less severe disease but you will still need to seek advice from the consultant consultant anaesthetist.
	<p>14.6 Neurological System</p> <ul style="list-style-type: none">• Epilepsy is not a contraindication, patients need to be individually assessed and referred to a consultant anaesthetist.• Patients with neuromuscular disorders require referral to the consultant consultant anaesthetist.
	<p>14.7 Gastrointestinal System</p>

Risk of regurgitation is not a contraindication for day surgery, but clear documentation of the risk is required, together with appropriate management on the day of surgery.

15. Mentally Unwell Patients & Patients with Learning Difficulties

Many of these patients benefit from a shorter stay in hospital and rapid return to their normal environment. The patient's usual medication should be given. A familiar carer should be present most of the time, including at induction and recovery from general anaesthesia.

16. Pregnancy

A pregnancy test must be performed if there is a possibility of pregnancy in all women of childbearing age (Age 12 -55). The consultant anaesthetist and surgeon should be informed if the result is positive.

17. Latex Allergy

If the patient is known to have a latex allergy, please refer to our Latex Allergy Protocol TEP 037.

18. Drug History

Medication should be taken as normal on the day of surgery unless advised by PAS nurse or consultant anaesthetist otherwise. Specific advice is needed for patients taking anticoagulants and insulin.

Aspirin, Clopidogrel, Dipyridamole & other antiplatelet drugs for prevention of myocardial infarct or cerebrovascular accident should be continued unless instructed by consultant anaesthetist or consultant surgeon.

The contraceptive pill or HRT should not be stopped unless specifically instructed by the surgeon. Oral contraceptives may need to be stopped in the 6 weeks prior to leg operations. Seek specific advice from the surgeon as prophylactic heparin may be prescribed.

Relative contraindication:

- Patients taking monoamine oxidase inhibitors (MAOIs). Seek advice from consultant anaesthetist.

Recreational Drug Use:

- Particular caution should be taken with patients using ecstasy or cocaine.
- Cannabis is not a contraindication.

- Patients using narcotics e.g. diamorphine (heroin) may experience difficulties with pain control post-operatively. Discussion about this should be documented.

The risk of using recreational drugs within 24 hours of general anaesthesia should be discussed with the patient and the outcome of the discussion recorded. Should the patient, be unwilling / unable to comply with local policy, advice should be sought from the consultant anaesthetist.

19. Anaesthetic

19.1 Anaesthetic History

Relative contraindication:

- Personal history of anaesthetic problems — need to obtain medical notes or details and then refer to the consultant anaesthetist. E.g. Suxamethonium apnoea, malignant hyperpyrexia, significant morbidity during or after anaesthesia.
- Details of any unexplained, significant morbidity in a relative during or after anaesthesia should also be noted and discussed with the consultant anaesthetist.

19.2 Airway assessment

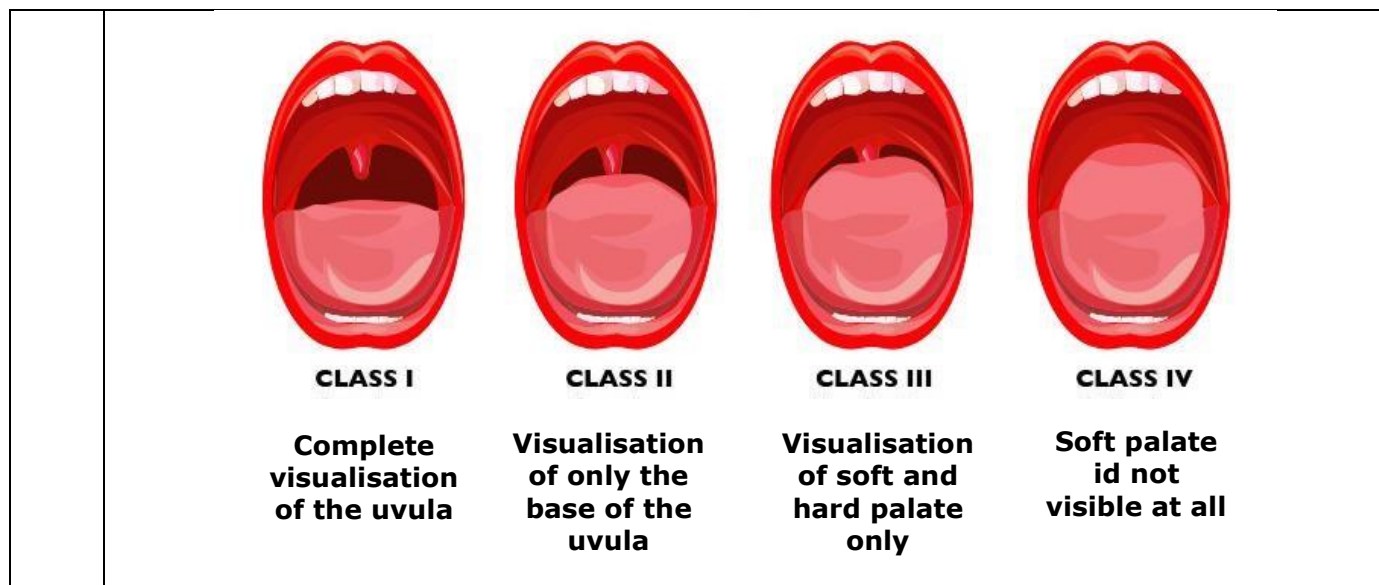
Contraindications:

- Patients who are unable to open their mouths, or who have very limited mouth opening.
- Known difficult intubations requiring fiberoptic laryngoscopy or other complex techniques are generally not suitable for day surgery due to lack of suitable equipment. Refer to consultant anaesthetist for advice.

Relative contraindications:

- Short, fat neck.
- Receding jaw.
- Mallampati grade 3 & 4 (see Mallampati pharyngeal assessment table).
- Restricted mouth opening.

Mallampati Classifications:



19.3 Thromboprophylaxis Assessment

The doctors use this during the patient’s admission to make an assessment of the patient’s risk of thrombosis.

20. Guidelines for Pre-operative Investigations

20.1 Principles

Investigations start with the taking of baseline observations — pulse rate and blood pressure - which may themselves highlight a problem e.g. hypertension, which would require treatment and stabilisation before the patient could be considered for surgery. Following the taking of a patient’s history, it may become evident that further investigations are required before the patient’s suitability can be confirmed.

Any investigation once ordered must be retrieved and examined and demands the time not only of the assessment nurse but also that of the consultant anaesthetist. It is important to remember that any investigation may result in a patient being cancelled.

Assessment, therefore, must occur within an acceptable period for the tests to be retrieved and checked. The assessment nurse must ensure that all tests have been carried out prior to surgery and care must be taken to safeguard that all test results have been checked thoroughly.

20.2 Investigations

Due to the COVID 19 pandemic all theatre patients are being screened 3 days prior to their procedure and are being asked to self-isolate from the time of the

test. Please see Standard Operating Procedure Restoration of Theatre Procedures from COVID-19 Pandemic – Low Risk Pathway for further information.

The possible types of further investigations are as follows:

1. MRSA Screening for all orthopaedic procedures or patients that have open wounds. Please refer to PTHB TEP 042 MRSA Protocol for further guidance
2. Biometrics before cataract surgery
3. Full blood count for:
 - a) Known or suspected anaemia.
 - b) Symptomatic cardiovascular or pulmonary disease.
 - c) Condition causing pre-operative blood loss.
 - d) Bleeding / bruising disease or history of bleeding / bruising disease.
 - e) Blood disorders, e.g. haemoglobinopathies such as sickle cell disease, thalassaemia.
 - f) Anticoagulant drugs.
 - g) Chronic disease e.g. rheumatoid, renal disease.
 - h) Hypo / Hyper Thyroidism
 - i) Arthritis
 - j) Diuretics – steroids or Lithium
 - k) Ace inhibitors – beta blockers or Digoxin
4. Clotting screen for:
 - a) Liver disease.
 - b) Bleeding/bruising disease.
 - c) Anticoagulant drugs.
5. Cholinesterase
 - a) If family history of Scoline Apnea (suxamethonium sensitivity)
6. Sickle Screening, Hb electrophoresis
 - a) Parents from, or whose parents are from, Africa, the Caribbean and Mediterranean countries. (Not necessary if patient has a card with sickle status on it, the consult anaesthetic lead would contact the haematologist if in doubt.)

- 7. Electrolytes, creatinine
 - a) Diabetes.
 - b) Renal disease.
 - c) Patient taking digoxin, diuretics, steroids, lithium.
 - d) Thyroid

- 8. Glucose
 - a) Diabetes.
 - b) Obesity.
 - c) Patient taking steroids.

- 9. Liver function tests (including clotting screen)
 - a) Liver disease.
 - b) Excess alcohol consumption (Please refer to alcohol screening tool **Appendix C**)

In PTHB we adapt to Cwm Taf Morgannwg HB pre-operative tests (In line with the National Institute for Health and Care Excellence (NICE) 2016 & agreement with the Pre-Operative Assessments (POA) consultant anaesthetists), please see table below detailing this:

Test	ASA 1	ASA 2	ASA 3 or ASA 4
Minor surgery - (examples: See procedure list – Appendix C)			
Full blood count (FBC)	No	No	Not routinely
Haemostasis (Clotting)	No	No	Not routinely
Kidney function (U&E)	No	No	Consider in people at risk of Acute kidney injury
ECG	Age <65 No	Age <65 No	yes
	Age ->65 Yes	Age ->65 Yes	
Intermediate surgery - (examples: See procedure list - Appendix C)			
Full blood count (FBC)	No	No	Yes
Haemostasis (Clotting)	No	No	Consider in people with chronic liver disease

Kidney function (U&E)	No	Consider in people at risk of Acute kidney injury	Yes
ECG	Age <65 No	Consider for patients with cardiovascular, renal or diabetes comorbidities & patients >65 years	Yes
	Age ->65 Yes		

Following the investigation, this will deem whether the patient is suitable candidate to have the procedure under day case in PTHB. Please see **Appendix B** for the templates we use for re-referral.

21. Fasting Guidelines

These guidelines are from AAGBI, 2011.

- For safety reasons, patients should not eat or drink prior to anaesthesia.
- The AAGBI recommends the minimum fasting periods based on the American Society of Anaesthesiologists (ASA) guidelines:
 - 6 hours for solid food
 - 2 hours for clear non-particulate and non-carbonated fluids.

The following patients should not be left for long periods without hydration, and may require intravenous fluids prior to surgery:

- Elderly patients.
- Patients who have undergone bowel preparation.

The chewing of gum is controversial but the pragmatic approach is to treat it as if it were oral fluid and prohibit for 2 hours pre-operatively. The greatest danger is of a foreign body potentially blocking the airway.

22. Psychological Parameters

Patients selected for day surgery may be uncertain of what lies ahead and may, as a result of a rushed outpatients appointment, present to assessment with many questions and concerns unanswered. In order to reduce anxiety the assessment be it face to face or telephone must allow enough time to answer patients' questions ensuring that they understand and are happy with the reply.

23. Assessment of Carers

A patient's initial recovery in the day surgery unit, the recovery continues at home with the emphasis of care being placed with the carer. Patients and carers must therefore, be fully informed about what to expect and what to do in the event of complications. Some patients may have unrealistic expectations, and it is the

responsibility of the day surgery unit to ensure that patients receive appropriate information on what to expect at home and how to manage. This information should be given in advance and not simply on the day of surgery as discharge information. Patients will only be discharged from the day surgery unit when they have met the discharge criteria, following discharge, some patients may experience nausea, headaches, muscle pains, blurred vision pain and possibly, anxiety associated having had a general anaesthetic. For ill-informed patients and carers this may cause considerable concern. This is why post-operative information must be available to the carer. The time taken to assess a patient's home circumstances and the carer during assessment will be time well spent. Some of the procedures will be such that patients will require district nurse support; the unit has a link with a community link liaison nurse. Other patients they may simply need to visit their GP practice nurse for removal of sutures.

24. Supporting Early Recognition & Management of Adrenal Crisis in Adults

Adrenal insufficiency is a rare disorder, which can lead to adrenal crisis and death if not identified and treated immediately. Adrenal insufficiency can be primary, secondary or tertiary as defined in Table 1.

The Association of Anaesthetists, The Royal College of Physicians and the Society for Endocrinology UK recommend that patients with adrenal insufficiency having body surface surgery need not be denied day case surgery, but that it is particularly important to ensure they have adequately recovered and are not suffering from nausea or vomiting, before discharge home, but due to PTHB community settings we recommend that any patient who has the any of the conditions listed in Table 1 below should **NOT** have their surgery in PTHB and be referred to a DGH. If there is any doubt the consultant anaesthetic clinical lead should be contacted.

Table 1: Causes of adrenal insufficiency

	Primary Adrenal Insufficiency	Secondary Adrenal Insufficiency	Tertiary
Cause	Failure of damaged adrenal glands to produce cortisol	Failure of damaged pituitary gland to produce enough AdrenoCorTicotrophin Hormone (ACTH), resulting in inadequate cortisol secretion	Suppression of hypothalamic pituitary axis

<p>Conditions</p>	<ul style="list-style-type: none"> •Addison’s disease (autoimmune) •Congenital adrenal hyperplasia •Congenital adrenal hypoplasia •Bilateral adrenalectomy. •Autoimmune polyglandular syndrome type 1 •Autoimmune polyglandular syndrome type 2 •Adrenal haemorrhage, metastasis, medications (cytochrome P450 inducers/inhibitors, monoclonal antibodies etc.), infections, amyloidosis. • Rare causes e.g. Smith-Lemli-Opitz syndrome, ACTH resistance, adrenoleukodystrophy (ALD), mitochondrial disorders. 	<ul style="list-style-type: none"> •Congenital hypopituitarism •Pituitary tumours •Pituitary surgery/radiation •Pituitary apoplexy •Sheehan’s syndrome 	<ul style="list-style-type: none"> •Exogenous steroid-induced adrenal failure
-------------------	--	---	--

All patients with conditions that cause primary or secondary adrenal insufficiency (Table 1) are physically dependent on daily steroid therapy as a critical medicine. Omission of steroid therapy in these patients can lead to adrenal crisis – a medical emergency which untreated can be fatal. Patients with adrenal insufficiency are at an increased risk of experiencing an adrenal crisis during periods of physiological stress such as inter-current illness, trauma or surgery, when increased doses of steroids are necessary. Incidents of adrenal crisis have also occurred on changing the formulation or route of administration for the steroid therapy. Prescribers are advised to seek advice from endocrinology services before changing the formulation or route of administration of steroid therapy to ensure dose equivalence.

Steroid-induced (tertiary) adrenal insufficiency, arising from suppression of the hypothalamic pituitary axis, may occur in patients prescribed high dose and/or prolonged courses of steroids for inflammatory and other conditions. Abrupt cessation of steroid therapy is a common cause. However, these patients may require additional doses of steroids, even after discontinuation of steroid therapy, during periods of physiological stress (acute illness, trauma or surgery) until full recovery of adrenal function.

Healthcare professionals caring for patients prescribed steroids, regardless of indication and/or route of administration, must be vigilant for signs and symptoms of adrenal insufficiency and crisis and manage the patient appropriately for these risks.

If a patient is unaware that they have any of the conditions listed in Table 1 above, and an adrenal insufficiency or crisis occurs during or following a procedure, the Association of Anaesthetists, in conjunction with the Royal College of Physicians and the Society for Endocrinology UK, have produced guidelines for Peri-operative management of glucocorticoids and state that anaesthetists must be familiar with the symptoms and signs of acute adrenal insufficiency so that inadequate supplementation or undiagnosed adrenal insufficiency can be detected and treated promptly.

25. Monitoring Compliance / Audit

The pre-operative assessment service should be continuously audited, where the results are sent to all professionals involved in pre-operative assessment, day surgery and to the theatre performance group. Action should be taken to ensure that services are continuously improved. Audit information should include:

- Number of patients who did not attend surgery following pre-operative assessment.
- Number of overnight stays, with reasons.
- Number of transfers
- Number of operations canceled on the day of surgery or the day before surgery because:
 - A. The patient said the appointment was inconvenient.
 - B. The patient no longer wanted the operation.
 - C. The consultant advised the patient that the operation was no longer necessary.
 - D. The patient had a pre-existing medical condition.
 - E. The patient did not follow pre-operative instructions.
- Number of operations cancelled by the hospital because essential resources (beds, surgeons, consultant anaesthetists, equipment, etc.) were not available.
- Staff satisfaction.
- Patient satisfaction.

26. Review and Change Control

This document will be reviewed every three years or earlier should audit results or changes to legislation / practice within PTHB indicate otherwise.

27. References / Bibliography

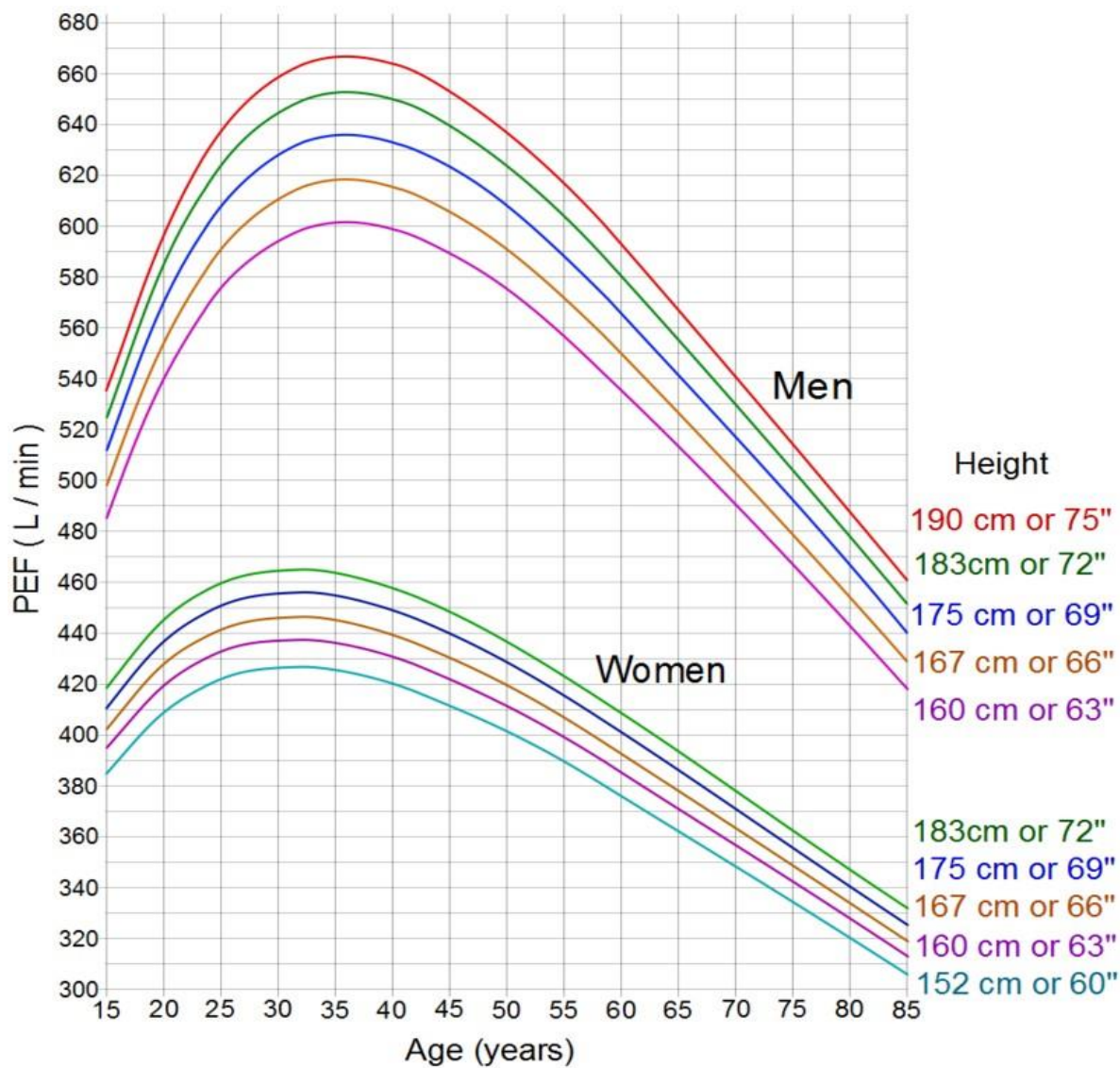
Routine Pre-operative Tests for Elective Surgery, NICE 2016

Standards and Recommendations for Safe Perioperative Practice, AfPP 2016

Guidelines for the Provision of Anaesthesia Services for Preoperative Assessment and Preparation, Royal College of anaesthetists 2019

Guidelines for Day-case Surgery, British Association of Day Surgery 2019

Normal Peak Expiration Flow (PEF)





Appendix B

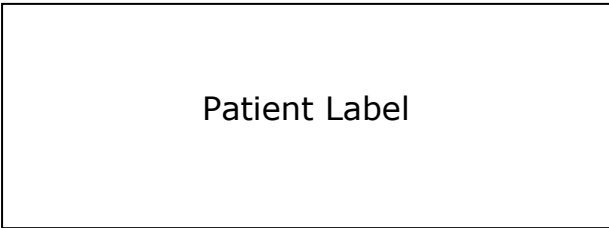
Referral to Consultant at DGH: Patient Unfit for Powys needs to have Procedure in DGH



Ysbyty Cofa Rhyfel Brycheiniog
Heol Cerrigcochion, Aberhonddu
Powys, LD3 7NS
Ffon: 01874 622443
Ffacs: 01874 615752

Breconshire War Memorial Hospital
Cerrigcochion Road, Brecon
Powys, LD3 7NS
Tel: 01874 622443
Fax: 01874 615752

Date:



Dear Mr/Dr

Planned Operation:.....

Pre-assessed:/...../.....

The above patient attended a Nurse-led Pre-Operative Assessment Clinic at Brecon / Llandrindod Wells Hospital today. **The patient has been deemed UNFIT TO HAVE THEIR SURGICAL PROCEDURE CARRIED OUT IN POWYS DUE TO:**

.....
.....
.....
.....
.....
.....

Tests carried out during assessment:

ECG **Bloods** **Peak Flow** **Blood pressure**

This patient will need to be placed on to your DGH waiting list for their surgical procedure to take place.

Please contact the Theatre Administrator on 01874 615689 if you have any queries or reference any action you would like us to take. The Theatre Administrator will remove the patients name from your Powys waiting list and will forward the patients referral letters etc. on to your secretary separately.

Pre-Anaesthetic Screening Nurse

Copy to: GP
Theatre Administration
Patient
S Williams Data/Audit Officer
Patient notes

Referral to GP: Patient found Unfit for Operation in Powys at the Present Time.



Bwrdd Iechyd
Addysgu Powys
Powys Teaching
Health Board

Ysbyty Cofa Rhyfel Brycheiniog
Heol Cerrigochion, Aberhonddu
Powys, LD3 7NS
Ffon: 01874 622443
Ffacs: 01874 615752

Breconshire War Memorial Hospital
Cerrigochion Road, Brecon
Powys, LD3 7NS
Tel: 01874 622443
Fax: 01874 615752

Date:

Patient Label

Dear Dr

Planned Operation:.....

Pre-assessed:/...../.....

The above patient attended a Nurse-led Pre-Operative Assessment Clinic at Llandrindod Wells Hospital today. **The patient has been deemed UNFIT TO HAVE THEIR SURGICAL PROCEDURE CARRIED OUT AT PRESENT DUE TO:**

.....
.....
.....
.....
.....

Tests carried out during assessment:

ECG Bloods Peak Flow

Blood pressure: 1st: 2nd : 3rd :

I have asked the patient to make an appointment with you for review of treatment and/or Further Investigation.

Please re-refer the patient by way of letter addressed to Operating Theatre Administrator based at Brecon Hospital when you have made a decision that the above problem has been investigated and resolved so that a further pre-operative assessment can be made for the patient.

Please note that the patients name has been removed from the waiting list whilst they undergo review of treatment and/or Further Investigation with you.

Pre-Anaesthetic Screening Nurse

Copy to: Powys patient services secretary for the consultant – to go as show note in next clinic
Theatre Administration
Patient
S Williams Data/Audit Officer
Patient Notes

Alcohol Dependency Screening Tool

Pre-operative assessment of patients with alcohol dependency

Introduction

The prevention of anaesthetic and surgical complications related to alcohol abuse is dependent on the accurate assessment of the volume of consumption at the pre-operative stage and the early detection of withdrawal symptoms. Unanticipated alcohol withdrawal in hospitalised patients can add to the risks and costs of the admission.



Both acute alcohol intoxication and chronic alcohol abuse can have a serious impact on peri- and post-operative mortality. This is largely due to the direct pharmacological interactions with alcohol and pathophysiological changes that can occur in dependency. The complications of a severe alcohol withdrawal are serious and potentially life threatening and therefore a thorough assessment at the pre-operative stage is essential.

The Alcohol Care Teams can assist in the assessment of these patients and provide advice regarding prophylaxis in terms of drug therapy or abstinence intervals. Brief intervention strategies can help prevent or ease some complications.

The Assessment

- At the pre-operative assessment complete the modified Audit-C score which comprise of the following 3 questions:

ALCOHOL SCREENING TOOL

UNIT GUIDE	
1 unit is typically: Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)	
The following drinks have more than one unit: A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)	

The following questions are validated as screening tools for alcohol use

AUDIT- C Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL						<input type="text"/>

- For those who score less than 5, a standard pre-operative anaesthetic assessment will be adequate.
- For those who score greater than 5, an email should be sent to the follow address with patient details and a history including both the proposed admission and operating dates. The indication for surgery should also be included:

AlcoholCareTeam.abb@wales.nhs.uk

- The Alcohol Care Team (ACT) will then assess the patient with the full Audit C score:

AUDIT Questions (after completing 3 AUDIT-C questions above)	Scoring system					Your score
	0	1	2	3	4	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	
TOTAL						

- For those who score less than 7, a routine pre-operative assessment will be adequate
- Those who score between 8-15, the ACT will advise accordingly regarding an appropriate detox regime and pharmacotherapy from the date of admission
- Those who score over 16 are potentially at high peri-operative and post-operative management. In these cases, the Consultant Anaesthetist and Surgeon should be informed so that the operation can be planned appropriately in conjunction with the ACT and Addiction Psychiatry team (led by Dr Julia Lewis)

- For those in the high risk group, particular attention to overall nutritional state and electrolyte imbalances including coagulopathies and thrombocytopenias may need to be considered.

Recommendations:


- All pre-operative anaesthetic packs should contain a copy of the alcohol pathway and modified audit c score (see appendix 1 and 2)
- Contact the Alcohol Care Teams on AlcoholCareTeam.abb@wales.nhs.uk for any queries or advice regarding patients with suspected alcohol abuse

Modified Audit C Score


ALCOHOL SCREENING TOOL

1 unit is typically:
 Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

UNIT GUIDE

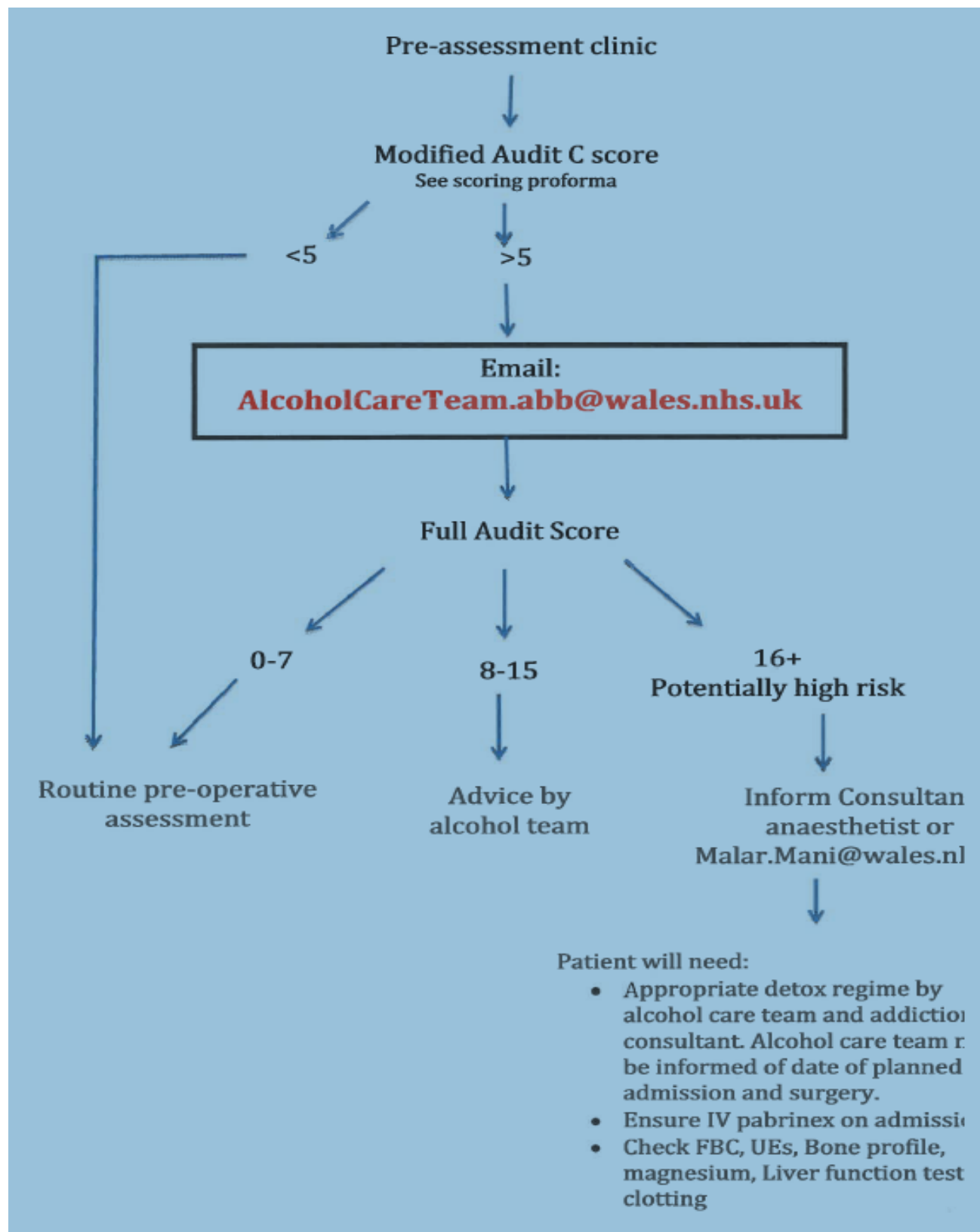


The following drinks have more than one unit:
 A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)

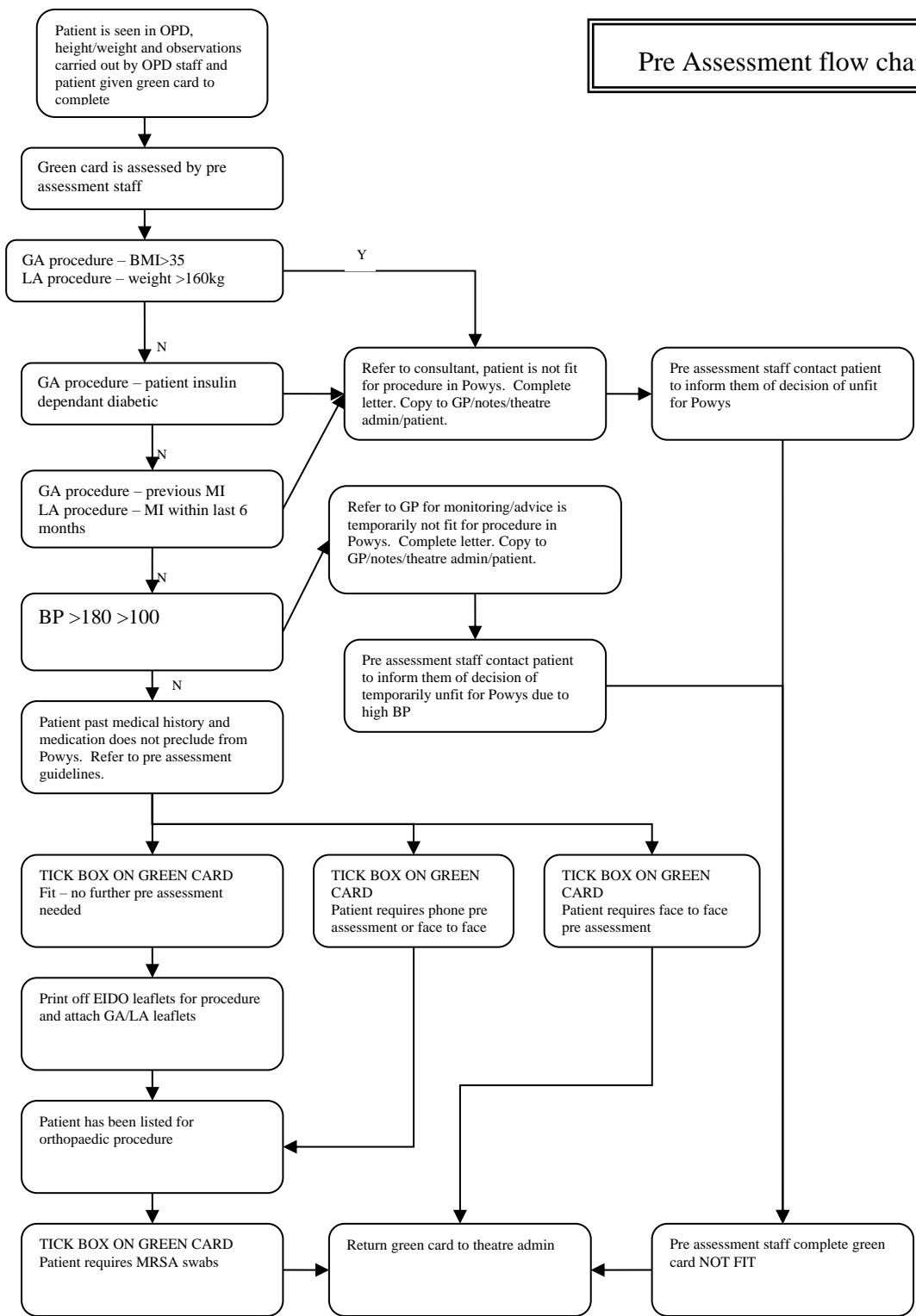


The following questions are validated as screening tools for alcohol use:

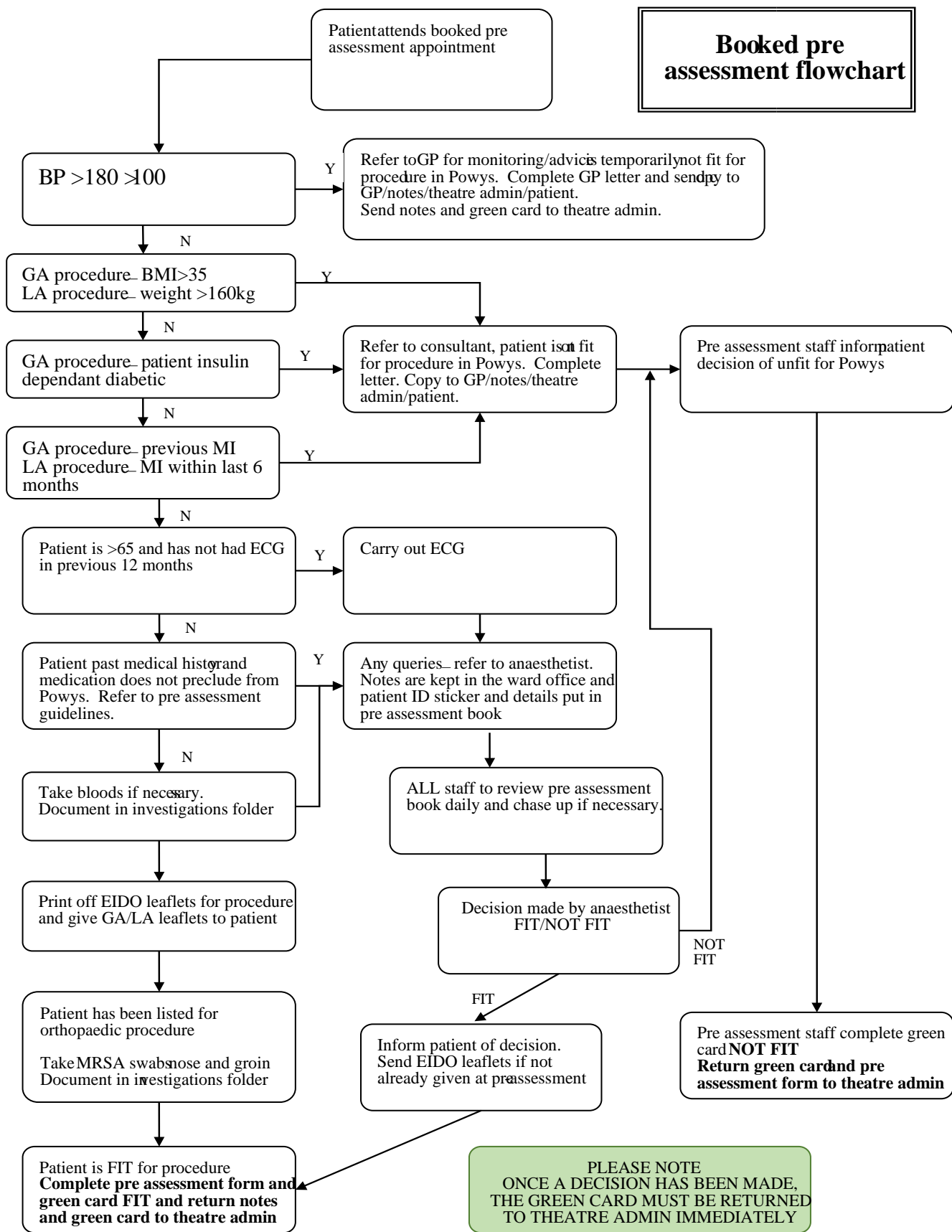
AUDIT- C Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 5 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
TOTAL						



Pre Assessment flow chart



Booked pre assessment flowchart



Booked pre flowchart updated April 2021