The Hidden Pandemic of Post-Operative Complications

-Notes from the Day

Notes from the Day

The Hidden Pandemic of Postoperative Complications

National Summit Meeting Notes

Adelaide, South Australia

06 March 2020

https://thehiddenpandemic.com

Notes from Summit discussion, principles

Table 9.

In relation to 'the principles'

1. Patient centred planning
- begin with primary care
- Needs to cater to each pt ie. Individualised
- Procedure vs No procedure
- Health literacy is focal and perhaps requires pre-hospital action eve at school
- Pt desired functional outcomes
2. Risk strategy with standard tool recognising shortcomings eg NSQIP
3. Systems – specifically individual/specific pathways, private and public
4. Primary care is key
- GPs are time poor
- Nurse educators
- Social media
5. Business case
    - Administrators
    - Funders (BUPA)
    - Bundled care

   Someone needs to take a punt on this and "grab it by the balls" because its feasible but unproven even though SWART, LUDBROOK, MYTHEN all show pockets of potential benefit with increased dollars upfront.
6. Incentives in public not just private; how do we incentivize surgeons to perform and behave as they do in private?

Table 10.

In relation to 'the principles'

1. All planning must be based around the person (their family, their expectations, needs and current situation).
2. Risks and benefits assessment should inform shared decision making when surgery is considered.
3. The pathway for perioperative cares tarts with primary care/primary referrer.
4. Not sure of purpose – jargon! Needs to include value.
5. Evidenced-based approaches should be used within all elements of the system (overlap with 3)
6. There is clear accountability and communication throughout the care journey.

Table 4.

What is missing from the principles?

Are they aspirational enough???

Needs to be all about the patient-partnership relationship

Leadership, culture and values need to change. Culture should underpin perioperative care and results in shared decision making, quality car and improved patient outcomes.

Quality comprehensive perioperative care is defined by health metrics and PREMS/PROMS and financially rewarded

Perioperative care should be guided by best evidence which informs future models.

Perioperative models of care should be multiD, integrated across the whole system and evidenced based.

How to put consumers at the centre…

Table 8.

What is missing from the principles?

How do we establish teams?

- Communication
- Work-flow
- Needs to be inclusive: junior staff, nursing
- Expectations surrounding communication: ward based, allied health, CONSISTENT MESSAGE. How do we deal with communication expectations, and sustaining the correct message:
    - Empowering people to own project
    - Every person is playing a big role
    - Pilot phase, then review before continuing
    - Culture change: recognise that it is a slow process, lag time.
- Patient journey diagram, communication at each point in the patient journey. Where do I fit in? Where can I have an impact?
    - Need a framework to hang it on

Point 3, do we need to risk stratify everyone?

- At this stage yes. But we don't identify and implement every time
- Counter argument- we need to focus on high risk patients. Would give us the biggest return on investment
- Should we screen and triage instead.
- What complications are avoidable, vs the one's that aren't- at what point are we wasting money

Point 7. Transparency

- Patient experience
- Harm and cost
- Quality of life, up to 90 days? Longer follow-up? EQ5D. We are not collecting that data
- How do we pick up this data? We can send them a questionnaire? What will the return rate be?
- Possibility of limited release? Why- some hospitals don't want to share their data with other hospitals. Is that acceptable? Important issues: the media cannot understand the data as it is presented

- ANZICS- SMR type plot data comparing hospitals, motivating. Data needs to be adjusted for emergency cases and complexity
    - Units can make adjustments based on their place in the pool
    - Hospital to hospital, before public data
    -

Point 1. Planning based around patient

- Clinic involvement in planning, multi-D, patient and family
- Patient and goals of care across the spectrum. Do patients know enough to be able to provide us with their goals of care?
- Event horizons are too short
- Avoidance of unnecessary surgery. Choosing wisely campaign, not well supported in the system. The painful knee statements. Why is this evidence-based approach not being implemented?
- Should we mandate a risk score before you can refer for surgery?
- Informed consent- consent for the 90 days post-operatively? And what the patient can expect, and what they are willing to accept?
- As part of a consenting proforma:
    - Risk documented
    - Goals of care documented
- *Should an expectation document be set in primary care?*
- Need to incentivise this process- possibly with bundled payment

Anonymous feedback 1

Empowering people – taking into account health literacy, culture, context. Including ACP.
Better equity.
Ensure personalise discussions and risk assessments
Understand what matters most to individuals so a tailor informed consent and goals of care.
Build systems for patients/person and not relying in current structures.
Outcomes need to be patient centred and incorporate cognitive and functional outcomes (?longer follow up)
Include everyone in education and information sharing (pt/family/other specialists who care for pt)
Using technology and AI to make processes easier including communicating to and from primary care to tertiary care providers
Business model needs to drive and sustain change.

Anonymous feedback 2

Patient centred surgical planning and informed consent must be influenced by the outcomes desired by the patient and individual risk of complications.
There should be a single system of perioperative care rather than silos
Funding should reward positive outcomes and integrated care across the patient journey
There must be transparency of outcomes available to all.
Care must be informed by the best evidence available.

Anonymous feedback 3

Appropriate risk adjusted performance measures should be in place to inform clinical governance to deliver quality outcomes.

Anonymous feedback 4

1. Patient centred upfront pre-operative assessment.
    - True Informed consent with; Goal determination; Risk screening
    - Before referral as a requirement
    - REFERRAL point is CRITICAL.
2. NSQIP and collaborator benchmarking
    - Involve Allied health
    - PT centred Outcomes measures, not just 30 day mortality.
3. Good adjacent nursing. Early anaesthetic assessment. Frailty assessments

The Hidden Pandemic of Postoperative Complications
National Summit Meeting Report
Adelaide, South Australia
06 March 2020
https://thehiddenpandemic.com

Notes from Summit discussion, themes, actions and recommendations

Theme 1. Placing the consumer at the centre of the surgical and perioperative journey

Table (a)

Goal 1:
The perioperative/surgical journey is planned through the eyes of the patient

Objectives:
Shared understanding of what could be done. What should be done and shared responsibility for a good outcome.

Actions:
All options of care are explained; where they have the associated risks and benefits explained in an understandable and meaningful way, so that the patient can make the best decision for them.

Goal 2:
Consumers should be involved in all levels of clinical governance, so that genuine co-design occurs.

Goal 3:
Centralised and easy access to a central repository, holding all the patients information so that the whole team has visibility of what has been done and what still needs to be done.

Action 1:
Process for explanation/contractual agreement
Importance agreed
Measure :

- audit officer (pt checking/immediate)
- post op phone call

Focus group
Start early

- written
- online

Give info
Check comprehension: (? clinical trial to evaluate this part)

- Allow to digest

- Teach back
- Talk back

Audit – real time. Carefully designed.
D'charge letters
Post op phone call: "was it what you expected?"

Action 2
Consumer on all development/grps
Diversity appropriate
Orientation needed
Consumers involved in audit/analysis
Consumer in on governance at all levels
KPI agreed/acknowledged

Action 3
Pathway

- Defined
- Mandated
- Decision pts

Visible to all – e.g. EMR

Anonymous feedback

- Key point is referral point by GP: need compulsory, systematic, patient centred information gathering (My Health Record) , preparation (reduce risk factors, patient goals (ACD), screening of patient risk for surgery, and true informed consent- all must occur beforehand be a requirement referral.
- Measure centred endpoint- not just 30 day mortality and morbidity- e.g. referral to aged care permanently, care at home
- More focus on dynamic feedback mechanisms- NSQUIP and SLS- with collaborative benchmarking- to promote change
- Focus on adequate and good quality nursing- levels
- Redesign pathway. Identifying what matters to the patient and incorporate into surgical and periop journey and outcome measures
- Improved collaboration across silos- including GPs- e.g. allow GPs to contribute to hospital safety learning systems
- Measure PATIENT centred and reported endpoints- not just 30 day mortality and morbidity- e.g. referral to aged care permanently, care at home
- How do we address patient risk and provide informed consent?
- Throughout periop journey need to know what outcomes important for patient and include risk of physical, cognitive function and social outcomes.
- Stratify patients. NSQUIP or other tool BEFORE referral, review by surgeon/anaesthetist, at admission point.
- Frailty assessment on admission.
- Goals of care/ACD as pre-requisite for surgery. End of life risk factor/assessment.

- Everyone attends pre-anaesthetic assessment- does not always require anaesthetist.
- How will Primary Care interact effectively with a system of perioperative care, considering this is usually the initial decision point for consideration of surgery.
- Compulsory before referral: information gathering, preparation of patient, goals of care assessment, surgical risk screening and then informed consent which is patient centred
- What key data are needed to drive quality, both on process and outcomes?
- Key data are what is relevant to consumer.
- QUALITY needs to be what consumers TELL us it is.
- Is the system designed in each delivery organisation for what is needs to do, for example if a hospital does mainly emergency work then the service delivery configuration should reflect that

Theme 2. Informed consent

Table (a)

Goal

Informed consent process will guarantee that the person/carer understands the purpose, process, risks, costs and benefits of the care process (pre, during and post procedure) so that they can decide whether to proceed or not.

Objectives

Informed consent process is individualised and reaffirmed through various stages of the care pathway

The process of informed consent is understood by all parties

The process needs to be established at the right time and include the whole care pathway

Actions

Task the ACSQHC to develop and incorporate into the National Quality Standards for health providers to:

Implement an evidenced based risk assessment tool for all patients

Implement a tool that helps all parties understand the goals/benefits of the procedure

Monitor the quality of the informed consent process vs the postoperative benefits & complications in the short, medium and long term

Task the ACSQHC in conjunction with Health Consumer's Forum to develop an education package for healthcare providers based on best education principles of adult learning in the achievement of informed consent and decision making including process for check back of patient re level of understanding

Commonwealth Gov in collaboration with the States, develop a funding model as part of integrated care to enable appropriate informed consent this may include changes to legislation to enable involvement of private health insurers.

Highest Priority Actions

1. Task the ACSQHC to develop and incorporate into the National Quality Standards for health providers to:

Implement an evidenced based risk assessment tool for all patients

Implement a tool that helps all parties understand the goals/benefits of the procedure

Monitor the quality of the informed consent process vs the postoperative benefits & complications in the short, medium and long term

1. Task the ACSQHC in conjunction with Health Consumer's Forum to develop an education package for healthcare providers based on best education principles of adult learning in the achievement of informed consent and decision making including process for check back of patient re level of understanding
2. Commonwealth Gov in collaboration with the States, develop a funding model as part of integrated care to enable appropriate informed consent this may include changes to legislation to enable involvement of private health insurers.

Implementation/Success Factors

From July 2021 ACSQHC has developed risk assessment tools which have been adopted by the College of General Practice and other stakeholders such as AMA and a training program has been run to incorporate the tool into general practice

New and alternative funding models have been developed to recognise the time commitment of GPs to utilise the risk assessment tool and other patient behaviour modification actions including managing patient expectations

Each state have established a perioperative care clinical network or equivalent with task to innovate and assist with the implementation of the standards (Champions)

A consumer education package is available on-line and through various social media mediums including U-Tube videos

Pilots have been implemented to test the application of the standards and the education package

From July 2022 the National Quality Standards incorporate the requirement that surgery is undertaken following risk assessment and informed consent

From July 2023 the College of Surgeons and other stakeholders have implemented a monitoring process to measure the quality of informed consent and operative outcomes Public and private funding arrangements have been reviewed comprise a range of bundled payments

Table (b)

Shared understanding of the risks, process, outcomes and timeframes.

1. Information
    a. College brochures
    b. Press
    c. Website
    d. Patient experience
2. Options
3. Risks
4. Outcomes

Ideal

Consultant led

- All high risk patients be seen by consultant in clinic for elective cases.
- All patients must be seen by a consultant at a time prior to arrival in theatre – even emergency cases
- If post-operative treatment intended then consultant also see.

Decision resource pack

- Printed version
- Web based resource
- Information explained.
- Lived experience resource.

<u>Theme 3. How do we address patient risk?</u>

Table (a)

In hospital team- what we can do tomorrow

1. Every patient seen in PAC gets a written risk assessment (or by the surgeon prior) (NSQIP possibly, ASA as absolute minimum)- *eventual goal is to move this further forward to the GP prior to referral*
    - Patient's shouldn't be given a date or a location for surgery until they have had a formal risk assessment (private and public)
    - (You cannot book a patient without a risk assessment)
    - This risk needs to be kept by the institution/ store data
2. Choosing wisely
3. Call patients at 90 days (for patient reported outcome)

Intermediate goals

1. Public relations campaign
    - What are patients' expectations regarding surgery and recovery? Knowledge about complications and the perioperative journey

Longer term implementation trial

- Empowering general practice
- Local engaged teams to trial implementation

Trial in a small group (i.e. Wangaratta, Mt Gambier, Wagga, Rocky)

- Theory is; try it at a country town where there is more consistent practice with GPs and relationships with the hospital

Pilot the process

- Risk assessment (NSQIP)
- Goals of care (number one priority)
- Complex case referral
- Bundle all three into My Health Record ideally (or letter to surgeon with copy kept by GP)
- Then from the hospital post op- letter back to the GP with complications, pain management and ongoing plan
- Could choose a single procedure to pilot the process on. Cholecystectomy? Joint replacements?

Anonymous

Throughout periop journey need to know what outcomes important for patient and include risk of physical, cognitive function and social outcomes.

Stratify patients. NSQUIP or other tool BEFORE referral, review by surgeon/anaesthetist, at admission point.

Frailty assessment on admission.

Goals of care/ACD as pre-requisite for surgery. End of life risk factor/assessment.
Everyone attends pre-anaesthetic assessment- does not always require anaesthetist.

Theme 4. How will Primary Care interact effectively with a system of perioperative care, considering this is usually the initial decision point for consideration of surgery.

GPs Need Tools
Screening by GPs – ?SORT/NSQIP/COMPASS
MEDICARE Periop Item

Issues:
Obesity
30% reduction

- Phe..?
- MDM

Culture
Investment and value

- Communication
- Risk assess
- GOC
- Complex cases referral

Observed vs expected outcomes

Need for a Complex referral pathway
Patient benefit/risk
Data cycle

- Improve overtime
- 90Days
- EQ5D
- Bonus

What Exists Now:

- Surgeons – timeout
- Risks assessment tools – Make a change - needed to book
- Choosing wisely
- Call patients at 90 days
- EQ5D
- Pre BP
- Primary health care
- Unplanned surgery
    - Need for on call geri's
- Data
- KPIs
- Financial
- Informed consent
- Incentives – Bundle of care package
- Shared
- Post op complications – linked to bundle payment.
    - Pneumonias
    - Wounds with return to OT
    - UTI
    - Unplanned ICU admission
- Periop unit – education; Culture change.

Anonymous
Compulsory before referral: information gathering, preparation of patient, goals of care assessment, surgical risk screening and then informed consent which is patient centred

Theme 5. What system responses are needed to drive ensure quality improvement?
Note: relevant input comes from a range of themes and table discussions., and the relevant notes are those provided under These such as: Patient Risk; Financial incentives; Key data

Theme 6. What key data are needed to drive quality, both on process and outcomes?

Table (a)

ONE Goal
To measure and decrease unwarranted variability in peri-operative complications by effectively and accurately measuring patient outcomes, and transparently sharing data in a

way that can be used to implement and drive change and inform the shared care team of the risk and benefit of the surgery/procedure.

Key Objectives

Objective 1

Describing the ideal model of care and identify the points at which we can measure against them.

Actions

- Define evidence-based, best practice protocols, pathways and models of care (e.g. Colleges, Special Interest Group, States/Territories or Commonwealth)
- To identify and access the funds to achieve this

Objective 2

To use data to decrease variability of care to enhance best clinical outcomes and efficient process

Actions

Objective 3

To ensure best practice models of care and KPIs are developed in collaboration with consumer and carer participation, as well as clinicians.

Actions

- Fund consumer engagement

Objective 4

- To ensure the data collection, analytics and communication encompasses the whole patient pathway, experience and preferences from referral to recovery.

Actions

- Create a place/house data and funds to set it up

What key data are needed to drive quality, (process and outcomes)

- Going to differ according to procedure type

Actions for these

KPI

What are the KPIs that show this patient has been optimised before elective surgery? (e.g wei

- To clearly define risk that supports good shared decision-making.
- Drive improvement
- Patient centred – PROMS/PREMS measure and use
- Mortality <2%
- Discussion of risk
- Aspects of pre-preparation
- Post op – eg return to theatre, readmission, infections, and then procedure specific

IMPLEMENTATION (relative advantage, compatibility, complexity, trialability, observability)

1: Identify high impact/high burden areas where improvement has be shown to make a significant and measurable difference (either area such as blood management OR surgical area eg joint replacement/ colorectal surgery)
2: KISS principle
3: Develop/import/implement best practice guidelines with evidence behind them that they make a significant and measurable difference
4: Develop indicators of success and achievement of guidelines (including PREMS and cost benefit)
5: Identify and support champions at all levels from regulatory to local unit level (top down bottom up)
6: Embed outcomes research into implementation
7: Publish and share the data (potential lever to drive individual wish to conform to mean)

Anonymous
Key data are what is relevant to consumer.
QUALITY needs to be what consumers TELL us it is.
Is the system designed in each delivery organisation for what is needs to do, for example if a hospital does mainly emergency work then the service delivery configuration should reflect that

Theme 7. Changing financial incentives/ driving equity within private/public sector

Table (a)
"Changing financial incentives/ driving equity within private/public sector"
Consider: goals, objectives and outcomes
Aim for one goal
Key objectives to achieve that goal
What are the strategies, objectives and actions?

Summary
One goal: complex case referral from primary provider. LIVING DOCUMENT
Doable, can be introduced with the platform we now have. Template goes in My Health Record

(Both sectors)
GP starts plan with goals of care and acceptable outcomes for patient. Initial risk stratification (yes/no/maybe surgery)

- Patient is then triaged out to the pathway most appropriate for the patient
    - Need to consider surgery type, patient factors
    - GPs should not be expected to work in isolation, need to be connected to team
    - Can you increase payment for higher risk patients, as long as they have good outcomes

- Document then follows patient through the journey to surgeons for further case discussion and risk stratification (including final decision yes/ no surgery)
- These discussions need to be funded. They should be rewarded for the assessment, and surgery OR not operating.
    - At the moment, surgeons are only paid for the procedure
    - 'Choosing wisely'
- Risk adjusted outcomes. Observed vs expected.
    - Compare surgeons (and their outcomes) to the expected outcomes. (need to ensure that expected is constantly updated, as the system improves)
    - Penalise for complications, and incentivise for reduction
    - Pulmonary complications + wound infections + UTIs
- Principle: incentivise prolonged complex discussion, surgery or no surgery, and link funding to observes vs expected outcomes
- GP to be incentivised to manage post-discharge outcomes

(The public sector)

- HAC penalties (in NSW for example) need to get to the local health network level and the specific site
- Is there scope to give bonus at 90 days (if the patient doesn't have a complication)? Criteria: Need to see that patient, and have a documented EQ5D

Limitations

- We need to pay the allied health team for attending and participating in these discussions

Funding

- Would have to be pooled funding (state and national level) to incentivise GPs through federal funding, where to hospital sees the savings in terms of LOS and readmission rate

Ideas:

- Public system is more straightforward
- In private: bundled payment system is the way forward. Would include primary care, geriatrics, pre-hab, rehab, allied health and back to primary care
- Bundled based around outcome
    - MBS outcomes
- How
    - Good conversations
    - Risk stratification
    - Informed consent
- Barrier: patient needs to be the customer.

Post-operative complications

- Needs to be incentivized, but how?
- Advanced resuscitation plan should be funded if done in primary care (for patient's prior to surgery)

Fundamental elements

- Communication
- Risk assessment
- Goals of care, and all options presented

Incentivising MDT meetings

- Can we fund meetings between all stakeholders, even for emergency surgery
- Need to check criteria for funding
- Does GP need to be involved?

Geriatricians in ED

- This needs to be funded, right decision made in a timely manner
- Can they have an in-facility assessment instead of coming in to hospital

Complex care pathway referral

- Needs to be mandated
- To ensure adequate GP/ primary provider risk assessment, goals of care and discussion

In private, how are anaesthetists incentivised to do pre-op clinic?

- No surprises, know patient well

Theme 8. Regulatory change

General notes

- Addressed under other themes, with additional points below.
- Develop a Federal regulatory framework that promotes improvements in perioperative care, though a National Policy on standards of perioperative care.
- Health systems are accredited against these standards.
- Funding reform to ensure that care providers are incentivised to provide integrated care against the standards
- Implement a "United" payment model to ensure joined up care – across Federal and State funding.
- Right to provide service and attract funding is tied to the standard.
- COAG determination to ensure access to data.
- Mandatory minimum data set
- Establish a National body for Perioperative Care

Table (a)

How to get a more accountable system culture and practice into system:

- "Restorative just culture"
- Reduce blame culture and encourage open disclosure – teaching and education key
- Will need resourcing and incentives to drive change
- Have systems to allow anyone to give feedback – including patients/carers/health care assistants/allied health (such as consumer engagement through NELA) – some patients wont have smartphones or computers so need to take into account to ensure equity
- Patient stories are powerful
- Objective analysis and way of feeding back so there is change and action, then reporting on change
- Takes into account human factors and performance management
- Need to know standard you're measuring against & get data on outcomes. Promote culture of auditing and sharing information/transparency
- Measure what is important to system –e.g. if ICU flow an issue then look at that and feedback

- Greater communication between those working in quality and safety and those working 'on the shop floor'
- Regular and ongoing auditing/date collection and reflection. Measure what matters and know what outcomes matter to patients/carer/whanau. Don't wait for people to opt in. Make it a requirement. Have set measures to look at and standardise inc patient related outcomes
- Feedback to everyone about outcomes regularly (inc primary care/primary referrer/paramedic etc)
- Promote positive outcomes and share learning
- Identify champions for change/early adopters
- Remember to measure outcomes and get feedback from patients who don't have operation/procedure
- Behavioural change including leadership. Make it relevant to those in the system
- Look at patient factors inc engagement, smoking

Action/implementation:

- Start conversations around advanced care planning/goals of care discussions and make communication medium (?online) which is available to primary and secondary care. May need funding. Lots of downstream benefits. Useful in elective and emergency surgery
- Introduce face to face/better visibility between consumers/health and safety/health care providers
- Education and promotion of difficult conversations & shared decision making
- Collect patient stories and promote periodically across health board – via newsletter/video/poster etc
- Make it a requirement to collect specific set data outcomes (standardise across Australia/NZ)
- Quality and safety groups collecting data, turn into format and make available to other healthcare staff and consumers
- Consumer engagement in developing hospital systems – qualitative and quantitative feedback

Theme 9 - Unplanned Surgery

General notes

- Rapid senior expert decision maker is available in a timely manner; is multi-disciplinary as required; is reviewed frequently against goals of care; includes decision not to operate; and includes early planning of discharge
- Consider whether organization of services, e.g. centralization of services or accessibility of ICU, should be undertaken for acute surgery; separation of acute and elective surgical work?
- Support co-location of acute surgical, trauma and orthopaedic services to enable efficiencies of scale and quality of care
- Internationally-recognised (?evidence based) standardised risk assessment is used to appropriately stratify care for the individual patient and drive quality improvement at

a system level. Use a standardized risk-stratification tool to guide care and objectives – see also under Risk Assessment
- Risk assessment results and multi-disciplinary feedback is used in shared decision making with patients – see also under Consumer at the Centre
- Acute surgical patients have a separate pathway from start to finish which avoid cross-over with elective surgery to improve in-hours access to acute surgery and minimizes cancellation of elective surgery – see also under Key Data
- Effectively use data for quality assurance, quality improvement and as a platform for research – see also under Key Data

Table (a)

Goals

- Improve morbidity psychological and physical and mortality for acute surgical patients
- Recognition of the burden of unplanned surgery and the need to appropriately fund at a health system/service level

Objectives

- Rapid senior expert decision maker is available in a timely manner and is multi-disciplinary as required
- Consider whether organization of services e.g. centralization of services or accessibility of ICU should be undertaken for acute surgery
- Support co-location of acute surgical, trauma and orthopaedic services to enable efficiencies of scale and quality of care
- Internationally-recognised (?evidence based) standardised risk assessment is used to appropriately stratify care for the individual patient and drive quality improvement at a system level
- Risk assessment results and multi-disciplinary feedback is used in shared decision making with patients
- Acute surgical patients have a separate pathway from start to finish which avoid cross-over with elective surgery to improve in-hours access to acute surgery and minimizes cancellation of elective surgery
- Effectively use data for quality assurance, quality improvement and as a platform for research

Actions

- Development of quality indicators which will enable health care staff, systems and patients compare outcomes across services
- Support early consultant-delivered decision making regarding the decision to operate
- Develop KPIs for acute surgery
- Ensure at least daily communication with the MDT and patient re plan of care and evaluation of care goals.
- Regular MDM approach to review and learn re KPIs
- Focus on common challenges / problems: falls, delayed discharge, hospital acquired infections

- Plan for safe, timely, effective discharge from day one.

Goals

- Improve morbidity psychological and physical and mortality for acute surgical patients
- Recognition of the burden of unplanned surgery and the need to appropriately fund at a health system/service level

Objectives

- Separation of acute and elective surgical work
- Use of risk stratification to guide care and shared decision making
- Effective use of data
- Effective, integrated, and co-ordinated teamwork

Actions

- Model activity resource separate elective and emergency theatres, team and ward space
- Use a standardized risk-stratification tool and outcome measures across Australia use this consensus group to select the tools eg. NELA
- Discuss with federal and state governments to incentivise payment models to operationalize this – unless you are involved in risk stratification and outcomes measurement – you won't
- Feedback and bench-marking of outcomes to health services and individual clinicians
- Leadership for recognition and reward of services as well as support and education with review cycles