ANZCA

FPM

Standards for Perioperative Medicine

Purpose

The purpose of this document is to articulate standards and associated indicators of quality care against which performance can be compared.

Scope

These standards are intended to apply to all medical practitioners whose practice falls within the scope of perioperative medicine.

Background

Perioperative care is the multidisciplinary, integrated care of patients from the moment surgery is contemplated through to optimal recovery. The care pathway spans risk and needs assessment, preoperative optimisation, prevention, and management of postoperative medical complications, and supports functional recovery.

Perioperative medicine is the science and practice of working with patients from the moment surgery is contemplated, to optimise their health and wellbeing, minimise the risk of perioperative complications, and facilitate optimal recovery, underpinned by shared decision making. Through all phases of the patient's journey, it complements the decision making and care delivered by others.

The Perioperative Medicine Team is led by medically qualified specialists, who perform risk and needs assessments, coordinate preoperative optimisation, prevent and manage postoperative medical complications where possible, and support functional recovery.

The Perioperative Care Team includes all individuals who may be involved in a patient's perioperative journey. This may include doctors, nurses and other health professionals in hospitals or clinics, as well as family members or other carers (see Figure 1).

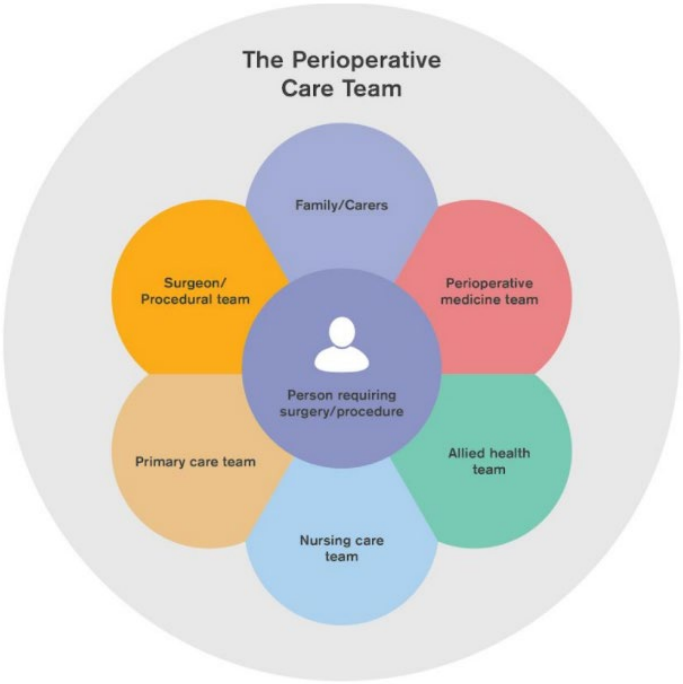


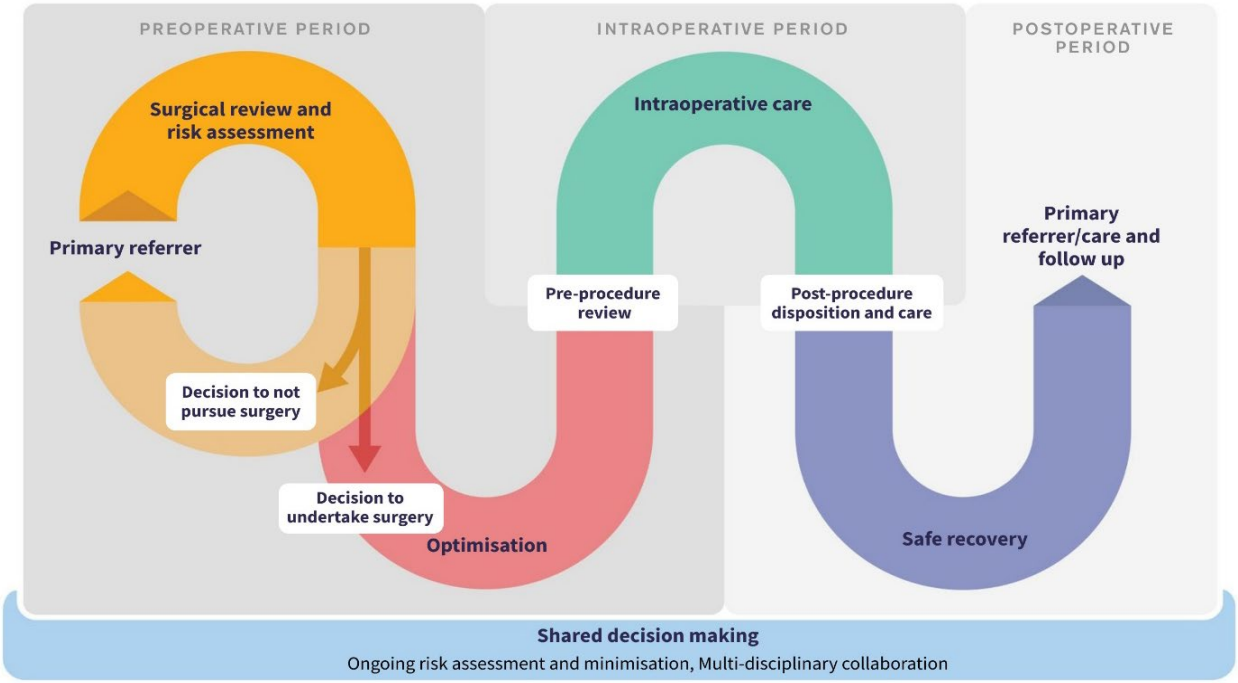
Figure 1: The Perioperative Care Team.

Goals of perioperative care

1. The patient is placed at the centre of all surgical and perioperative preparation, planning and postoperative care (see Figure 1).
2. The patient is cared for by a coordinated and integrated multispecialty and multidisciplinary team with a clear leader and clear lines of accountability.
3. Individualised risks are identified in a standardised and consistent way, starting early in the perioperative journey, and shared with the patient, their family and all individuals involved.
4. Timely assessment of risks to allow optimisation of medical status, acuity and for triage and streaming to the best pathway of care, including levels of postoperative care.
5. All options for care, including non-operative care, are presented to the patient and their family for consideration to enable informed shared decision making.
6. Defined goals and plans for perioperative care are agreed to and understood by the patient, their family, and all individuals involved in their care.
7. Decision making at all stages is shared by clinicians, patients, their carers and family, and clearly communicated to all stakeholders.
8. Improved outcomes through the delivery of coordinated, integrated, effective and equitable services, modified as needed by data and research.

Refer to Background section in *Standards for Anaesthesia* and Glossary section in *Documents Framework Policy* for definitions of guidelines, position statements and policies

Aspects of perioperative care



Standard 1: Professional

Patients are cared for in a professional, culturally sensitive, and ethical manner by a multispecialty team whose members are registered, qualified specialists working within their defined scope of clinical practice, with the ability to evaluate their own performance and the overall performance of the Perioperative Medicine Services.

Standard 2: Preoperative care

The patient is placed at the centre of all surgical and perioperative preparation, planning and care and has clearly articulated goals of care, (including the option of alternative procedures or no surgery) so that they present in optimal condition, understanding the risks and benefits of the proposed procedure and are enabled to participate in shared decision-making.

Standard 3: Intraoperative care

All intraoperative care provided, meets the standards of the relevant college, regulators, and standard setting bodies, and follows best practice guidelines.

Standard 4: Postoperative care

Post procedure disposition and care achieves optimal patient comfort and recovery, and the discharge plan is communicated to and understood by all, including the patient and their primary referrer/primary care physician.

Standard 5: Healthcare facilities

Healthcare facilities are managed in accordance with regulatory requirements, with coordination of personnel and systems to support safety and quality in perioperative care.

Aspects of perioperative care

Professional

Standard 1: Patients are cared for in a professional, culturally sensitive, and ethical manner by a multispeciality team whose members are registered, qualified specialists working within their defined scope of clinical practice, with the ability to evaluate their own performance and the overall performance of the perioperative care service.

Indicators

1.1 Training and qualifications.

Perioperative care is provided by registered medical practitioners who work as part of a multispecialty and multidisciplinary team with other registered healthcare professionals. In addition to clinical expertise there is a moral and ethical requirement to act in a professional and ethical manner. Guidance is provided by the regulatory authorities[1, 2].

Specialists in perioperative medicine have completed their relevant speciality college fellowship requirements and have a qualification in perioperative medicine – for example Graduates of the Chapter of Perioperative Medicine of ANZCA, (GChPOM), which is an advanced inter-specialty clinical qualification in perioperative medicine.

1.2 Leadership and teams.

Perioperative medicine includes a multidisciplinary team (MDT) that ideally includes general practitioners (GPs) and allied health professionals. Perioperative medicine is a consultant led service. It is strongly encouraged that the lead consultant has completed inter-specialty training, such as that of the Graduate of the Chapter of Perioperative Medicine of ANZCA (GChPOM).

The lead consultant of the Perioperative Care Team has an appreciation of the need to engage all the relevant specialities within the team to ensure adequate expertise, collaborative team decision-making and effective communication.

Perioperative medicine specialists demonstrate the required skills and abilities to communicate effectively and respectfully with all team members to promote the collective performance of members in achieving optimal outcomes.

[1] *Good Medical Practice New Zealand*,
[2] *Good Medical Practice: Code of Conduct for Doctors in Australia*

They are able to evaluate their own performance and the overall performance of the perioperative medicine service. However, they encourage and welcome feedback from the multidisciplinary team members.

1.3 Cultural competence and cultural safety.

Perioperative medicine specialists practice in accordance with cultural safety guidelines. The broad spectrum of personal circumstances and identities from which patients present is acknowledged and valued, and all patients are cared for with respect and dignity.

Training in cultural competence and cultural safety and understanding of cultures within their frames of reference is an essential component of any perioperative medicine program. Following granting of qualification, an ongoing commitment to indigenous health, linguistic and neurological diversity, cultural competence and safety is fulfilled through continuing professional development (CPD) activities, including audits, educational activities, patient experience surveys and other relevant activities

Refer to *PS62(G) Position statement on cultural competence* for further information.
Refer to NSQHS Standards for Aboriginal and Torres Strait Islander health[3].
Refer to Ministry of Health NZ Te Tiriti o Waitangi[4].

1.4 Wellbeing.

Perioperative medicine specialists understand and appreciate the importance of physical health, mental health and wellbeing in clinical performance and patient care. Good patient care is enhanced by specialists who are healthy and experience wellbeing.

Resources for wellbeing are in place to facilitate the development and maintenance of strategies that maintain the ability of specialists to provide high quality care through their career. Wellbeing is an individual, collegial and organisational responsibility.

Refer to *PG49(G) Guideline on the health of specialists, specialist international medical graduates and trainees* and *PG43(A) Guideline on fatigue risk management in anaesthesia practice* for further information.

1.5 Professional citizenship/community.

Perioperative medicine specialists fulfil leadership, educational and advocacy roles within their college or specialist societies, and other national societies/bodies to maintain the strength of the profession in Australia and New Zealand. They work collaboratively to ensure the standards of Perioperative medicine are achieved and built on, to promote safety and quality for those requiring perioperative care.

[3] NSQHS Standards for Aboriginal and Torres Strait Islander peoples
[4] NZ Ministry of Health's Te Tiriti o Waitangi

Clinical – perioperative systems and processes

Standard 2: Preoperative care

Patients are placed at the centre of all surgical and perioperative preparation, planning and care and have clearly articulated goals of care, or the course of management to allow for non-operative care, so that they present in optimal condition, understanding the risks and benefits of the proposed procedure and are enabled to participate in shared decision-making.

Indicators

2.1 Risk assessment and risk modification are performed.

Patients for complex surgery, or who have complex comorbidities have an individualised risk assessment, using a standardised tool. This is recorded in the patient notes. The urgency of the surgery does not mitigate the need for risk assessment.

A comprehensive preoperative assessment is performed that integrates specific patient goals, patient and procedural urgency and facility resources to inform the shared decision-making discussion.

Comprehensive geriatric assessment (including a frailty assessment) is available to meet the breadth and depth of patient populations undergoing surgery.

Refer to *PG07(A) Guideline on pre-anaesthesia consultation and patient preparation* for further information.

2.2 Patients are optimised following preparation and planning.

The Perioperative Medicine Team (POMT) monitors and coordinates the pathway to surgery to ensure optimisation targets for modifiable risk factors (beginning in primary care) are met without unnecessary delay, in the context of the procedure and available resources.

2.3 All decisions are the result of shared decision making (SDM).

Shared decision making is a collaborative process between patients, carers and healthcare professionals to bring together the patient's values, goals, and preferences with the best available evidence about benefits, risks and uncertainties of treatments (including non-operative treatment) to reach the optimal decision for that patient. It underpins the communication strategy to the whole team including the primary referrer.

The goals of care, advanced directives (where they exist) and discussions pertaining to shared decision making, are documented. Policies and procedures are in place to allow this to occur routinely.

Refer to the following documents that requires revision to include Perioperative Medicine *PG07(A) Guideline on pre-anaesthesia consultation and patient preparation*[5], *PG12(POM) Guideline on smoking as related to the perioperative period*[6], *PS26(A) Position statement on informed consent for anaesthesia or sedation*, *PG62(G) Position statement on cultural competence*, *PG15(POM) Guideline for the perioperative care of patients selected for day stay procedure* and *PG06(A) Guideline in the anaesthesia record*[7].

Standard 3: Intraoperative care

All intraoperative care provided meets the standards of the relevant college, regulators and standard setting bodies, and follows best practice guidelines.

Refer to standard 3 section in Standards of Anaesthesia for further information.

[5] PG07(A) currently under review.
[6] PG12(POM) currently under review, next version to include vaping.
[7] New professional document equivalent to PG06 needs to be developed to include perioperative medicine.

Standard 4: Postoperative care

Post procedure disposition and care is resourced to achieve optimal patient safety, comfort and recovery. The discharge plan is communicated to and understood by all, including the patient and their primary referrer to ensure seamless and effective continuity of care.

Indicators

4.1 Postoperative disposition and level of care is planned preoperatively and subsequently modified according to needs.

Postoperative disposition and level of care is agreed preoperatively (and modified if necessary) so that the requisite level of monitoring and early intervention is present, to prevent avoidable complications.

Defined processes and escalation pathways that promptly identify and manage criteria-based patient deterioration are in place.

4.2 Formal handover and communication is provided to all those involved in postoperative care.

Structured handover occurs to the relevant team members who may have ongoing input in the postoperative period. This formal handover is documented and includes anticipated early postoperative risks, specific clinical needs, and post PACU, HDU/ICU destination.

Anaesthetists continue to provide immediate care during the postoperative period until such time as this is no longer required, or care has been handed back to the proceduralist and/or to another qualified registered medical practitioner working within their scope of practice.

Alongside the surgical team, the perioperative medical team/delegate may contribute to discharge planning and rehabilitation to reduce complications and improve short- and long-term outcomes.

The patient and their family are kept informed at all stages of the recovery about the plans and expected outcome.

4.3 End of life care is provided in accordance with the patient's preoperative goals and wishes.

4.4 Processes exist to ensure optimisation of primary referrer/care, continuity of care and follow up.

Timely and accurate handover includes a comprehensive medical plan, which considers the patient's physical, social and functional needs, including their ability to access primary, secondary, tertiary level and allied health care.

The discharge plan is communicated to the patient (and family), the primary referrer and their primary care team, and includes a clear point of contact for addressing concerns, complications or side effects.

Refer to Standard 4 in Standards of anaesthesia for further information.

Healthcare facility support of clinical environment

Standard 5: Healthcare facilities

Healthcare facilities are managed in accordance with regulatory requirements, with coordination of personnel and systems to support safety, quality, and value in perioperative care.

Indicators

5.1 Data.

Recognised perioperative datasets including standardised risk assessment tools are used to allow hospitals to benchmark patient and system outcomes.

5.2 Safety metrics.

A set of interdisciplinary, agreed safety metrics for perioperative medicine sensitive to patient outcomes and processes/systems are used as an audit tool to accurately measure unwarranted variability in perioperative complications. Metrics for all parts of the pathway are needed to improve the safety and quality of patient care,

Healthcare facilities actively participate in registry and quality improvement programs advocated by national professional bodies or relevant regulators or departments/ Ministry of Health.

This data can be shared to drive compliance with best practice models of care.

Refer to Standard 5 in Standards of Anaesthesia and *PG58(A) Guideline on quality assurance and quality improvement in anaesthesia* (needs modification) for further information.

Professional documents of the Australian and New Zealand College of Anaesthetists (ANZCA) are intended to apply wherever anaesthesia is administered and perioperative medicine practised within Australia and New Zealand. It is the responsibility of each practitioner to have express regard to the particular circumstances of each case, and the application of these ANZCA documents in each case. It is recognised that there may be exceptional situations (for example, some emergencies) in which the interests of patients override the requirement for compliance with some or all of these ANZCA documents. Each document is prepared in the context of the entire body of the college's professional documents, and should be interpreted in this way.

ANZCA professional documents are reviewed from time to time, and it is the responsibility of each practitioner to ensure that he or she has obtained the current version which is available from the college website (www.anzca.edu.au). The professional documents have been prepared having regard to the information available at the time of their preparation, and practitioners should therefore take into account any information that may have been published or has become available subsequently.

Whilst ANZCA endeavours to ensure that its professional documents are as current as possible at the time of their preparation, it takes no responsibility for matters arising from changed circumstances or information or material which may have become available subsequently.

Promulgated: 2023
Current document: Dec 2023

Ongoing document development:

1. **Revision of existing documents to include perioperative medicine:**

PS04(A) Position statement on the post-anaesthesia care unit

PS53(A) Position statement on the handover responsibilities of the anaesthetist

PS41(G)Position statement on acute pain management

PS45(G) Position statement on patients' rights to pain management and associated responsibilities

PG67(G) Guideline for the care of patients at the end-of-life who are considered for surgery or interventional procedures

PS02(A) Position statement on credentialling and defining the scope of clinical practice in anaesthesia

PS42(A) Position statement on staffing of accredited departments of anaesthesia

PG58(A) Guideline on quality assurance and quality improvement in anaesthesia

PG65(G) Guideline for the performance assessment of a peer.

2. New documents required:

Post anaesthesia safe recovery and discharge planning.

Perioperative multidisciplinary team.

Duties of a perioperative medicine specialist.