Pre-operative

1. Shared decision making
2. Active preparation and optimisation
3. Early planning and practical preparation

Early post-operative period

4. Promoting DrEaMing
5. Setting expectations

Rehabilitation

6. Early review of planned discharge location

Discharge

7. Patient education and empowerment
8. Criteria-led discharge
9. Safe transitions of care

Prepared for Surgery, Ready for Recovery: Supporting Patients from Pre-op to Discharge

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Shared decision making

Ask

GP / primary care team at referral (or admitting team if emergency surgery)	Surgical team (doctors/ CNS) corroborate at OPD (or as inpatient if emergency surgery)	MDT corroborate at high-risk clinic	Pre-op practitioner corroborate at POA

About the patient

- **Who** they live with?
- **What** caring responsibilities?
- **Where** they live (e.g., own home, hostel, sheltered accommodation, residential home, nursing home)?
- **When**/if need support with ADLs?*
- **Why** need support?
- **How** coping currently?

Do

GP / primary care team at referral (or admitting team if emergency surgery)

Share information

As a minimum include following on referral to inform shared decision-making conversations:

- Place of residence (e.g., own home, hostel, sheltered accommodation, residential home, nursing home)
- If patient lives alone or with others
- Absence/presence of formal care package

It can be helpful to consider:

- Any informal care or support
- *Frailty score*
- Comorbidities
- Any ACD, ADRT, DNAR or LPA for health**

Contents

*ADLs = activities of daily living
**ACD = advanced care directive, ADRT = advance decision to refuse treatment, DNAR = do not attempt resuscitation, LPA = lasting power of attorney

Next

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Ask

Surgical team (doctors/CNS) at OPD (or as inpatient if emergency surgery)	MDT at high-risk clinic	Pre-op Practitioner at POA

About what is important

Find out from the patient what is important to them - their values, beliefs, preferences and goals.

Use this information, the frailty score and referral letter information to inform *shared decision-making* discussions.

It can be helpful to consider:

- What are the **benefits**?
- What are the **risks**?
- What are the **alternatives**?
- What if they **do nothing**?

Do

Surgical team (doctors/CNS) at OPD (or as inpatient if emergency surgery)	MDT at high-risk clinic	Pre-op practitioner to reinforce at POA	Clinical Nurse Specialist to reinforce at surgery school

Set expectations

Check that outcome of surgery matches patient's expectations.

Signpost to any surgery specific patient education e.g., virtual / in person surgery schools, videos, patient leaflets

Provide patient (and carer) with realistic information about:

- Suitability for daycase
- If inpatient, anticipated length of stay
- Anticipated timescales for cognitive, functional and psychological recovery
- Anticipated temporary, or permanent, increase in care needs post-operatively
- Anticipated temporary, or permanent, restrictions on health or lifestyle

Communicate these expectations to wider healthcare team to ensure consistent messaging.

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Active preparation and optimisation

Do

Everyone to make every contact count	GP / primary care team at referral	Surgical team (doctors and CNS) at OPD	MDT at high-risk clinic	Pre-op practitioner at POA	Clinical Nurse Specialist at surgery school

Encourage active preparation

Active preparation rather than passive waiting can improve patient outcomes, shorten length of stay by 1-2 days and reduce complications by up to 50%.

Encourage patients to adopt small lifestyle changes related to:

- Smoking cessation
- Alcohol moderation
- Physical activity and exercise
- Weight management and nutrition
- Mental wellbeing

Signpost patients to resources to prepare for potential elective surgery

- *Things to ask, think about and do if you might be having an operation*
- *FitterBetterSooner* (in 25 languages)
- *CPOC*
- *Add to your life* (NHS Wales)

Think

Surgical team (doctors and CNS) at OPD	MDT at high-risk clinic	Pre-op practitioner at POA

About prehabilitation

Specialist prehabilitation can increase preoperative fitness and reduce complications, length of stay and readmissions.

Is the patient eligible for specialist prehabilitation service (where service is available)?

Think

GP / primary care team at referral	Surgical team (doctors and CNS) at OPD	MDT at high-risk clinic	Pre-op practitioner at POA

About optimisation

The sixth key component of active preparation is *assessment*, optimisation and shared decision making

Is there scope to optimise medication?
STOPP/START review (page 17-20)

Is there scope to optimise comorbidities?

- *Diabetes*
- *Anaemia*
- Hypertension

Think

Surgical team (doctors and CNS) at OPD	MDT at high-risk clinic	Pre-op practitioner at POA

About frailty

Patients living with *frailty* have a 4-fold increased risk of post-operative complications

If *clinical frailty score* ≥ 5 think about, or check If had, referral to perioperative frailty team, for comprehensive geriatric assessment (or use *frailty intervention tool* [page 23-25], if no perioperative frailty team)

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Early planning and practical preparation

Think

Elective: Pre-op practitioner at POA	**Emergency surgery:** nursing team on admission ward

About home care

Consider how patient will manage at home after operation

- Is patient currently independent?
- If not, do they have informal support or formal care?
- How are they coping currently?
- Is there a support network to provide additional help in postoperative period?
- If daycase surgery planned – is a named adult available for 24 hours after surgery?

Do

Surgical team (doctors and CNS) at OPD (or as inpatient if emergency surgery)	MDT at high-risk clinic	Pre-op practitioner at POA	Clinical Nurse Specialist at surgery school

Encourage practical preparation

The seventh, and final, key component of active preparation is practical preparation.

Encourage patients to think about how they will cope with ADLs such as washing and toileting, dressing, mobilising, shopping, meal preparation, housework and transportation post-discharge.

Signpost patients (and carers) to *our resources* or procedure specific resources.

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Ask

Elective surgery: Pre-op practitioner at POA	**Emergency surgery:** nursing team on admission ward

About transport

Ask the patient (or carer):

- How will you get to hospital for operation?
- How will you get home when discharged?

Do

Elective surgery: Pre-op practitioner at POA	**Emergency surgery:** nursing team on admission ward

Escalate

Escalate any anticipated complex discharges (e.g., patients with no fixed abode, patients with anticipated significant change in care needs requiring new social services input) to matron / discharge team lead / homeless coordinator (so discharge planning can start before admission)

Consider delaying routine elective surgery until clear discharge plan agreed.

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Promoting DrEaMing

Do

Surgeon in theatre	Recovery staff on ward handover	Ward team (nursing and HCSW) on shift handover

Be clear with handover

Drinking (free fluids), eating (soft diet) and mobilising (from bed to chair) within 24 hours of surgery reduces length of stay by 37.5%. 1

Despite the clear benefits, research indicates 30% of patients do not do all three within 24 hours of surgery. 2

Clearly document on operation note/ in medical notes and verbally handover to recovery staff (who can then verbally handover to ward team)

- When patient can resume drinking
- When patient can resume eating
- Any restrictions on intake (e.g., soft diet)
- Any restrictions on mobilising. For orthopaedic surgery: use standard terminology e.g., *non weightbearing, limited weightbearing or unrestricted weightbearing*

On handover at start of shift ask:

- Has patient been DrEaMing?
- Are there any restrictions on drinking or eating?
- Do they need any assistance with feeding?
- For orthopaedic patients: what is the weight-bearing status (*non/limited/ unrestricted weight-bearing*)?

Think

Surgical team (doctors and CNS)	Ward nurses	Therapies team

About barriers to mobilising

Consider potential barriers to mobilisation:

- Clearly document plan in notes (including weight bearing status for orthopaedic patients) to remove uncertainty
- Document reasons for not removing catheters, drains and drips (which impede mobilisation)
- Review pain scores and analgesia
- Use and share knowledge of how to support a patient to safely mobilise (see next page)
- Consider patient's emotional needs (see next page)

Theme 3

1 *Updated DrEaMing CQUIN for 23/24*

2 *Perioperative Quality Improvement Programme*

Next

Do

Ward nurses (supported by HCSW)

Support safe mobilisation

It is **not** necessary to wait for physiotherapy assessment before encouraging a patient to mobilise after surgery.

Consider the following:

- Does the patient have their glasses and hearing aids (if applicable)?
- Do they have well-fitting slippers or shoes?
- Is their blood pressure stable?
- Have they had analgesia?
- Can they follow commands and gestures?
- Can they change position in bed?
- Can they safely sit on edge of bed?
- Can they safely stand upright?
- Can they lift one foot off the ground, then the other?
- *Give it a go*

If mobilising out of bed is not possible, consider bed-based exercises to reduce risk of deconditioning.

Think

Ward nurses and HCSW | Therapies team

About emotional needs

Some patients find active participation in their recovery empowering, but others feel vulnerable.

Reassurance and consistent messaging may help some patients feel confident and safe, and allow them to actively engage with their post-operative care and recovery. 3

3 *https://www.journalslibrary.nihr.ac.uk/hsdr/GHTY5117*

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Setting expectations

Think

Surgical team (doctors and CNS)	Ward nurses (supported by HCSW)

About deconditioning

Hospital admission can lead to functional decline, decreased muscle mass and reduced cognition, especially in elderly patients.

Consider how changes to the ward environment and ethos can prevent deconditioning e.g., *#EndPJparalysis*

Do

Surgical team (doctors and CNS)	Ward nurses

Set progress goals

Set realistic goals for the patient e.g.,

- Getting washed and dressed in day clothes
- Sitting out in a chair for increasing durations, including at mealtimes (unless documented exception)
- Mobilising increasing distances, including to the bathroom

Theme 4 Theme 6

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Early review of planned discharge location

Ask

MDT (surgical team, ward nurses, therapies team, discharge support team) on ward round or board round

Share information

Patient's time is important, especially for patients anticipated to be in last 1000 days of life. [1]

On the ward round or board round, to avoid unnecessary delays to discharge, consider:

- Is the patient meeting progress goals?
- What is keeping the patient in hospital?
- What is needed for today to be a green day (a day of value, progressing towards discharge) rather than a red day (a day of no value)? [2]

Ask

MDT (surgical team, ward nurses, therapies team, discharge support team) on board round

About rehabilitation potential

Discuss rehabilitation potential with MDT at daily board round. Consider:

- Is the patient engaging with therapies and nursing team?
- If not, what are the barriers?
- How can the barriers be overcome?
- Is the patient back to baseline?
- If not, are their increased care needs fixed or temporary (i.e., do they have rehabilitation potential?)
- Would the patient (and carer) benefit from signposting to resources and/or assessing equipment needs?

Theme 5

1 *Last 1000 Days*

2 *Rapid Improvement Guide to: Red and Green Bed Days*

Next

Ask

Ward nurses	Therapies team	Discharge support team

About support networks

Consider how patient will cope with ADLs (activities of daily living) e.g., washing and toileting, dressing, mobilising, shopping, meal preparation, housework and transportation

Ask the patient:

- Who can support you when you go home from hospital? (if additional support needed consider availability of alternative support networks e.g., voluntary organisations)

Ask the family / friends:

- Are you able, and willing to support when the patient goes home from hospital?
- If so, how?
- Are there any concerns you have about providing support?

Do

MDT (surgical team, ward nurses, therapies team, discharge support team) on ward round or board round

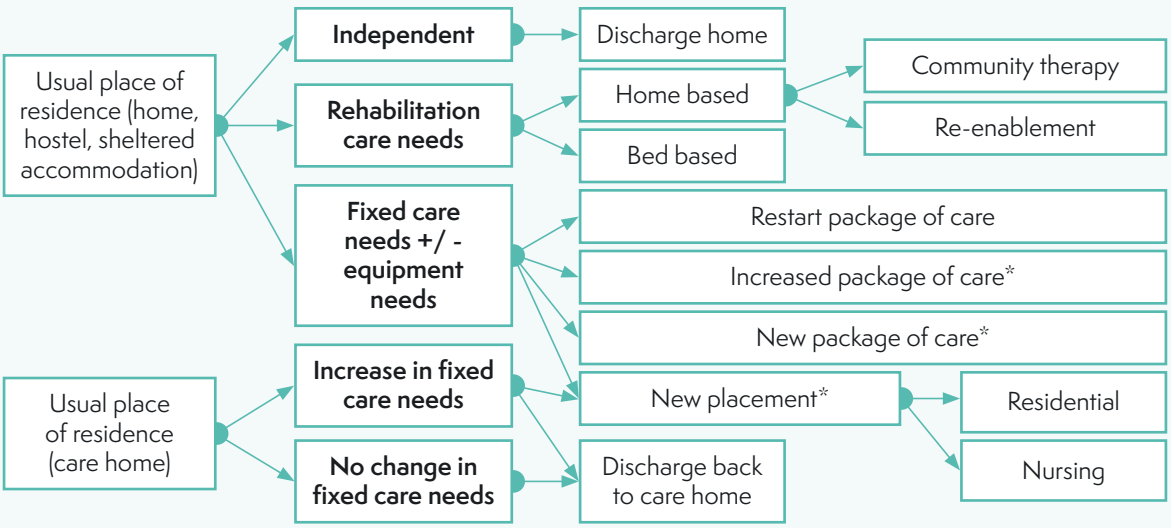
Share information

As an MDT, on board round, use the information about:

- progress;
- fixed or temporary increase in care needs;
- availability of support networks;

...to confirm if return to normal place of residence is possible.

Alternatives may need to be considered to prevent unnecessary delay in discharge (see diagram below).



*If delay anticipated, consider step down from acute bed

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Patient education and empowerment

Do

Everyone

Educate and empower

Ensure patients (and carers) have sufficient information for safe discharge and feel reassured by:

- providing procedure specific patient information
- pre-empting and encouraging questions
- explaining who to contact in event of a problem

Consider the following:

Surgical team	Anticipated milestones for recovery Activities to aid recovery e.g., smoking cessation, weight management or improving nutrition, building up physical activity Any restrictions on activity e.g., return to work (provide fit note of appropriate duration), driving, flying, heavy lifting When to seek medical attention Any need for extended pharmacological thromboprophylaxis Use of opioid analgesia (including side effects, how to taper dose, safe storage and safe disposal)
Nursing team	Care of any dressings, drains or catheters How to administer LMWH Plans for aftercare (e.g., district nurse visits, outpatient appointments)
Therapies team	Exercises to help with recovery Approaches to managing at home with ADLs
Dieticians or nutrition team	Any dietary restrictions Care of any enteral feeding tubes
Pharmacy team	Any changes to medication Any need for extended pharmacological thromboprophylaxis Use of opioid analgesia (including side effects, how to taper dose, safe storage and safe disposal)

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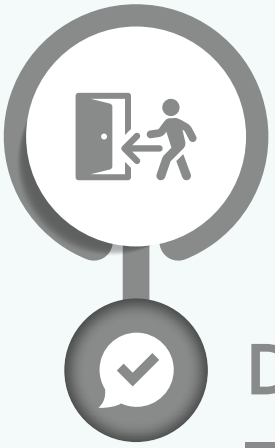

Criteria-led discharge

Do

Consultant surgeon

Adopt criteria led discharge

Discharge after daycase surgery should be criteria led [1], with no minimum time between operation and discharge (except for procedures with risk of haemorrhage)

Discharge criteria:

1. Pain controlled with oral analgesia
2. Nausea and vomiting controlled (or acceptable for transfer home)
3. Patient tolerates oral fluids
4. Patient can mobilise safely
5. Patient has stable observations

The need to pass urine before discharge is only relevant if:

- spinal anaesthesia
- urology procedure
- gynaecology surgery for incontinence

Theme 7

1 https://www.gettingitrightfirsttime.co.uk/wp-content/uploads/2024/09/National-Day-Surgery-Delivery-Pack-V2.0-September-2024.pdf

Next

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Safe transitions of care

Do

Surgical team (doctors and nurse prescribers)	Prompted by ward nurses and discharge support team

Discharge prescription

Communication is essential for patient safety at transfers of care.

The discharge prescription should be a timely written communication with primary care provider which summarises:

- hospital admission
- relevant interventions
- medication on discharge
- next steps

For more information see *here*

Prepare the discharge prescription as soon as possible, ideally the day before discharge. This is especially important if:

- an ambulance is required for discharge
- patient usually has their medication in a compliance aid (e.g., blister pack or pillpouch)
- medication is being administered via an enteral feeding tube

Do

Ward nurses	Therapies team	Clinical Nurse Specialists

Supply equipment

Assess the need for, and supply, any equipment necessary for discharge e.g., crutches, commode, catheter bags, stoma bags

9 Discharge

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Ask

Ward nurses and discharge support team

About transport

Check with patient (or carer):

- How will they get home (e.g., relative / friend, taxi)?
- Do they have a door key?

Do

Surgical team (doctors and CNS) | Ward nurses

Explain next steps

Ensure patient (and carer) are aware of any planned follow-up including:

- Removal of sutures / drains
- Wound checks
- Physiotherapy
- CNS or consultant review (if formal follow up is required)

If no formal follow-up required ensure patient (and carer) are aware how to access help if they have concerns e.g.

- Patient initiated follow-up (PIFU)
- See on symptoms (SoS)
- Primary care consultation

Do

Ward nurses and discharge support team

Share information (with other HCPS)

Care transitions (e.g., from hospital to home) can be a patient safety risk, especially in those with more complex needs.

To ensure seamless transition of care, ensure relevant information is shared with other healthcare professionals where applicable e.g.

- Ambulance service
- District nursing team
- Residential or nursing home staff
- Specialist services e.g., stoma nurses, palliative care team, anticoagulant service

Back