THE NEW MODEL OF CARE

THE NEW MODEL OF THE PREOPERATIVE PROCESS

The common conceptual basis of the new preoperative system is to plan all stages of care of an elective surgery patient as a unified and integrated process. A cross-specialty and multidisciplinary clinical service *(the Perioperative Service)* manages the assessment and preparation of all elective surgical admissions. When an operation is being planned, a hospital-based clinical service gathers information about the patient from the surgical team, from the patient (e.g. by interview or questionnaire), from the patient's GP and from other health providers. This is used to triage the patient to an appropriate level of preparation complexity, with selective use of outpatient clinic attendance prior to admission. Patients attending clinics are assessed by a multi-disciplinary team, predominantly nurses and anaesthetists. The Perioperative Service team then coordinates preparation until admission, including communication to relevant hospital care providers.

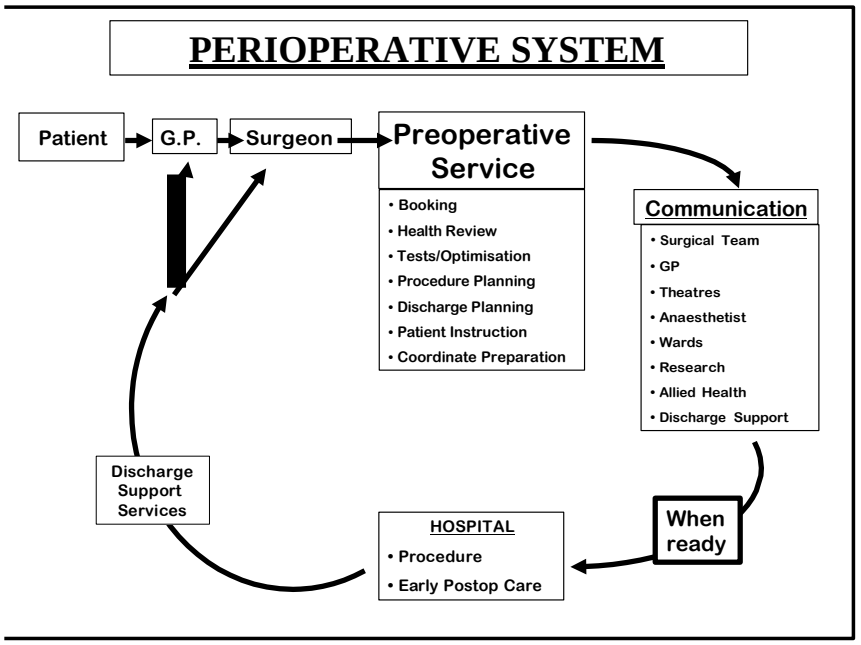
KEY FEATURES

- *Pre-admission patient preparation*
- *Selective clinic review*
- *Day of Surgery Admission*
- *Centralized Preoperative Care*
- *"Hot Bedding"*
- *Planned hospital care & discharge*
- *Elective surgery centrally organised & coordinated by a multidisciplinary Perioperative Service*
- *Ongoing service development and clinical process redesign 'driven' by the Perioperative Service*

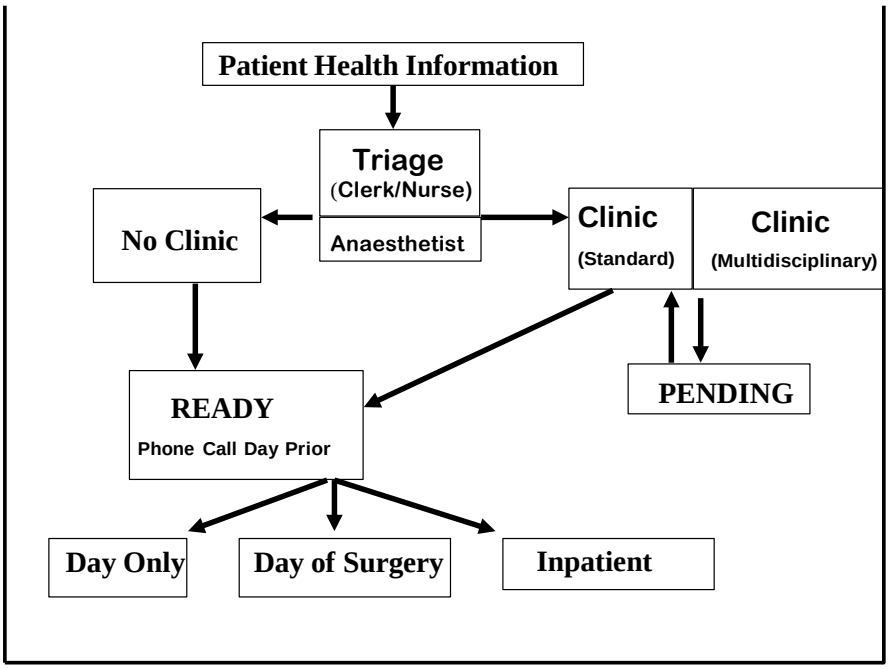
The new preoperative process can be conceptualised graphically (Fig 3). Comparison with earlier figures of the traditional system makes clear the shift in emphasis away from in-hospital activity. Patient assessment and preparation commences at the time of booking, and patients do not enter hospital until ready for their procedure. Communication with all care providers is a major focus of activity. Care planning (particularly discharge planning) occurs proactively.

The preadmission assessment process can also be shown graphically (Fig 4). Information about the patient gathered by questionnaire or from other sources is used to triage the patient into groups needing no clinic-based assessment, 'simple' clinic assessment, or multidisciplinary assessment. Non-clinic patients are given preparation instructions (e.g. printed instructions by mail), and have any further necessary preparation managed by telephone (e.g. a call on the evening prior to admission).

Some patients who attend for clinic assessment will be postponed pending further investigations, medical stabilisation etc. All patients are then admitted either as Day Only (DO) patients; Day of Surgery Admission (DOSA); or Inpatients (i.e. admitted on the day before surgery). With appropriate preparation, over 90% of admitted patients (i.e. excluding Day-Only) can be managed as DOSA patients. This includes major vascular, neurosurgery, orthopaedic and cardiothoracic patients.



(Fig 4)



(Fig 5)

The new model of care represents a substantial clinical process redesign. The establishment of the Perioperative Service is both a result of this redesign, and a platform for ongoing redesign. Thus the functions of the Perioperative Service include both clinical service delivery, and ongoing driving of clinical process redesign.

ORGANISATIONAL CONSIDERATIONS

The Perioperative Service is a clinical service. Therefore it will needs the same organisational infrastructure of any other clinical service (see box). As a new service working to deliver a new model of care, this infrastructure may take some time to develop. The function of the service shall tend to be suboptimal until all the necessary infrastructure is established. Local characteristics such as numbers of patients, clinical complexity, financial drivers, workforce skills, space constraints, and intra-organisational politics shall determine the particular organisational features of any perioperative service in any particular institutional setting.

- *Staff – Nurses, Clerical, Medical & Allied Health .*
- *Budget*
- *Accommodation (Clinic plus Office area)*
- *Equipment*
- *Policy & Procedures*
- *Medical Clinician Leader/Director (Generally an anaesthetist)*
- *Service Manager (Generally a Nurse)*
- *Executive Sponsor*
- *A Place in the Organisation Chart*

STAFF & LEADERSHIP

As a clinical service, a service manager (generally with a theatre or surgical ward background) and a designated medical clinician leader/director is required. These roles are complementary. The function of the service, particularly in driving clinical process redesign, will be constrained until both positions are filled by clinicians with appropriate seniority and authority. Among the responsibilities of the Medical Director is taking clinical responsibility for policies and procedures and clinical decision-making such as deciding on preoperative tests and investigations, and preoperative prescribing. An appropriate statement of position responsibilities for the medical director must be developed and agreed by the institution, in particular to clarify 'turf' issues with other medical clinicians. In the USA, the responsibility for ordering preoperative investigations has been a focus of this 'turf war'. This appears to have been less controversial elsewhere.

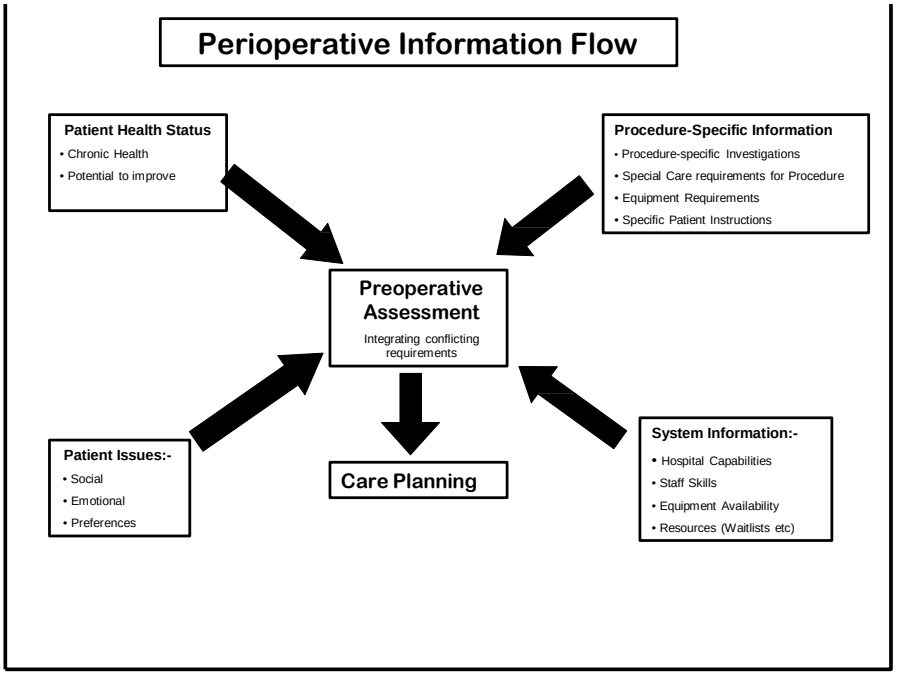
WORKFORCE CHANGE

Workforce change is intrinsic in the new preoperative systems, and inevitably includes task transfer or substitution, transfer of skills, and extension of roles.
Extension of roles by nurses into areas traditionally considered the domain of medical staff is both necessary and inevitable, but requires training and skill transfer. Many of the tasks involved in preoperative assessment, particularly information gathering and handling, are performed more effectively by 'clerical' staff than by clinicians such as nursing and medical staff. This involves of extension and upgrading of traditional clerical roles to become 'para-clinical' staff.

For all staff, but for anaesthetists in particular, there is a "philosophical" debate as to whether to the process they are involved in is 'pre-anaesthetic' or 'pre-operative' assessment and preparation. More broadly, this is a debate about whether the process (and those working in it) are aiming to provide a 'gatekeeper' or a 'roadmaker' function. (See later comments.)

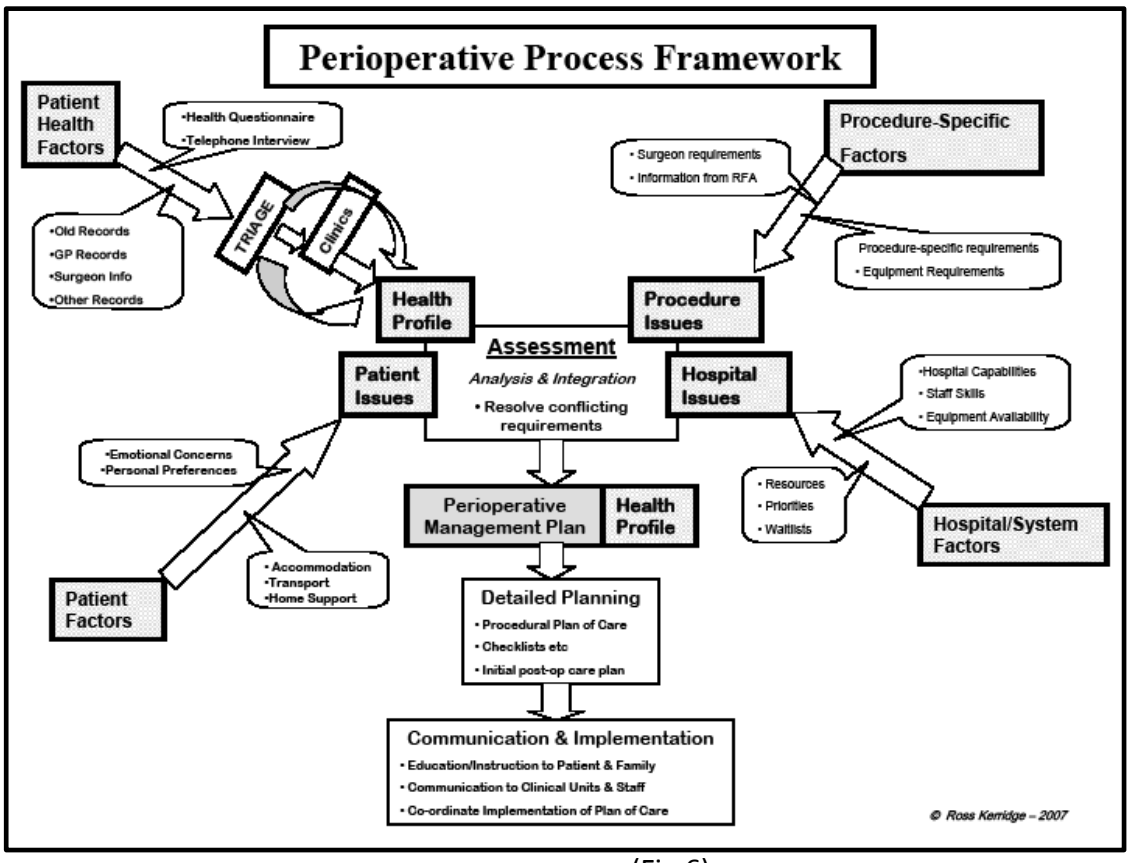
RECONCEPTUALISING THE DECISION FRAMEWORK

The 'new' model for preoperative assessment is a change in clinical processes. It can also be thought of as representing a change in information flow and decision-making in preoperative preparation. As discussed previously, the traditional model of care was based on relatively simple, linear information flow and decision-making. The new model and be conceptualised as based on four separate sources of information and input into decision-making in the preoperative process. These four areas are:- (i) the surgical information and procedural requirements (ii) the patients health status (iii) the health system or hospital requirements; and (iv) the patients personal preferences and requirements. These areas all need to be considered during preoperative assessment and to enable optimal preparation. A simple representation is shown.



(Fig 5)

The patient assessment process involves bringing together information in all these categories, integrating the information, identifying areas of conflict requirements, and developing a plan to manage all the various demands from the different 'stakeholders' in the preoperative process. The various intersecting and conflicting demands can be integrated and developed into an overall 'strategic' plan. This strategic plan can then be further developed into a detailed plan, which can then used to manage the particular episode of care. This can be shown in the more detailed graphic (Fig 6). Note the flow of information and decision-making in the patient health stream. Information is gathered to enable triage. Some patients need to attend for clinic-based preparation. When this is completed, the patient's health is summarised in a Standard Health Profile. This information is integrated with surgical, system, and patient factors to make a perioperative assessment and plan. This is used to enable detailed planning for the episode of care.



(Fig 6)

In summary, 'new' preoperative assessment involves integrating the health status of the patient, the surgical requirements, the patient's personal requirements and preferences, and the system's requirements, to make an overall 'strategic', and then a detailed, plan of care.