

1. Introduction

The document details the criterion for adults having minor and intermediate surgical procedures under anaesthesia and anaesthesia led sedation within the Alliance at Melton Mowbray Hospital, Hinckley, District Hospital and Loughborough Community Hospital.

The Royal College of Anaesthetists (2014) defines a remote site as any location at which the anaesthetist is required to provide general/regional anaesthesia, or sedation away from the main theatre suite and/or anaesthetic department and in which it cannot be guaranteed that the help of another anaesthetist will be available. This may either be within or away from the base hospital. The Alliance is a remote site and therefore surgical admission criteria are required to reduce the risk of transfer out to the main UHL site.

2. Scope

This document does not cover the clinical management of the patient presenting for pre-operative assessment and preparation or surgery. Any clinical concerns relating to the patient's fitness to proceed to surgery or the complexity of the surgery must be escalated to the Anaesthetist and Consultant Surgeon, as appropriate and in a timely manner.

Patients for Endoscopy and for procedures under local anaesthesia are outside the scope of this document.

3. Recommendations, Standards and Procedural Statements

Pre-operative assessment (POA) is key in determining the suitability for surgery within the Alliance; the presenting comorbidities of the patient and the impact on health and functional status a detailed.

Functional Status

The preoperative assessment should be a holistic overview of a patient's health status. This includes assessing functional status or exercise tolerance which is a major determinant of perioperative risk. Patients should have a detailed history taken about their functional status and this should be documented. Details on limiting symptoms should be recorded. The Metabolic Equivalent (MET) classification is used as an assessment of functional status. Patients who are able to achieve activities consistent with 4 METS are generally suitable to proceed with day case type surgery. 4 METs is the energy requirement associated with light housework e.g. hoovering, independent living and climbing a flight of stairs. If there is uncertainty about the patients functional status tools such as the Duke Activity Status questionnaire can be useful. Further guidance is given in the table below:

METS

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|---------------------------------|---------|
| Taking care of yourself | <4 METS |
| Walking around the house | |
| Walk at slow pace (2-3 mph) | |
| Light shopping | |
| Walking at normal pace (3-4mph) | 4 METS |
| Light house work | |
| Leisure cycling | |
| Climbing 1 flight of stairs | >4 METS |
| Climbing 2 flights of stairs | |
| Walk up a hill | |
| Run a short distance | |
| Scrubbing floors | |
| Brisk swimming | |

Surgery grades

Surgery grades aligned to SORT calculator

<http://www.sortsurgery.com/index.php>

| Surgery grades | Grade of Surgery |
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| Minor | <ul style="list-style-type: none"> • Excising skin lesion • Draining breast abscess • Core biopsy lesion of breast • Adenoidectomy • Removal of grommets • Examination of vagina under anaesthesia as sole procedure |
| Intermediate | <ul style="list-style-type: none"> • Adenotonsillectomy – bilateral • Tonsillectomy – Adult • Septoplasty of nose (including attention to turbinates) • Phakoemulsification of cataract and lens implant unilateral (topical or local anaesthesia) • Primary repair of femoral hernia • Primary repair of incisional hernia not requiring mesh • Primary repair of inguinal hernia • Carpal tunnel release – open • Cubital tunnel release without transposition • Hysteroscopy (including biopsy, dilatation, curettage and resection of polyp) • Hand – Partial amputation of digit |

The following list includes the surgical procedures completed within the Alliance and while not exhaustive, is a key consideration in theatre scheduling and planning to ensure that the proposed procedure and complexity of such is appropriate for the Alliance.



Day case procedures
(excluding Endoscopy)

ASA grades

The ASA (American Society of Anesthesiologists) Physical Status Classification System is a simple scale describing fitness to undergo an anaesthetic. The ASA states that it does not endorse any elaboration of these definitions. However, anaesthetists in the UK often qualify (or interpret) these grades as relating to functional capacity – that is, comorbidity that does not (ASA 2) or that does (ASA 3) limit a person's activity.

<https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system>

Surgical admission criterion

The following admission criterion will be used to determine patients that are suitable for elective and expedited day case surgery within the Alliance

| | Suitable for Alliance | Not suitable for Alliance | Rationale / Comments |
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| BMI | BMI below 35 having minor/intermediate surgery BMI 35-40 to be discussed with Anaesthetist | BMI >40 BMI <18 | Fitness for day case surgery should not be limited by assessment of BMI in isolation and should be in consideration of other co-morbidities and functional status There may be increased risks associated with longer laparoscopic operations and these should be timed for early on a list |
| ASA | ASA 1 and ASA 2 ASA 3 for Local Anaesthesia | ASA 4 patients ASA 3 for GA/sedation – Not suitable ASA 3 patients with significant functional | Fitness for a procedure should relate to a patient's functional status and not be limited by |

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| | | limitations which would limit suitability for day case surgery | ASA status alone. |
| Cardiac | | | |
| Hypertension | Blood pressure controlled in community i.e. below 160/100 on GP or home reading within 12 months (AAGBI, 2016) | If BP in community is over 160/100 with evidence of end organ damage (i.e. renal impairment / LVH by voltage criteria) | There is no clear evidence that patients with BP below 180/110 without end organ damage have increased perioperative cardiovascular risk. Assessment of a patient's cardiovascular risk should consider other risk factors. |
| Valvular disease | Mild valvular disease/stable – LA only Ensure recent ECHO available <2 years and ECG taken – discuss with Anaesthetist | Diagnosed valve disease – History of collapse, shortness of breath on exertion, abnormal rhythm | Asymptomatic patients often tolerate non cardiac surgery well. However the risk of complications increases with valve disease severity. Patients with moderate to severe lesions should be managed in a centre with 24 hour access to cardiology on site cover. |
| Pulmonary Hypertension | | Clinical or echocardiographic signs of right heart failure and any decline in functional status | Surgery is expected to have increased risks in patients with pulmonary hypertension |
| Pacemaker | | Cardiac Resynchronisation Therapy Implanted defibrillator Pacemaker | |
| MI | >6 months ago with minimal angina and good functional status i.e. CCS | MI within 6 months | Surgery can be a risk factor for myocardial ischaemia and |

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| | 1-2 | On-going restrictive angina since MI (CCS 3-4) MI with occluded vessel being medically managed | recurrent MI. In the presence of a reduced functional status due to angina and overnight stay is prudent for observation. |
| Coronary angioplasty/stenting/CABG | Procedure completed > 6 months Minimal symptoms of angina since procedure and good exercise tolerance >4 METS Should be discussed with Anaesthetist | Coronary angioplasty/stenting/CABG completed less than 6 months ago Patients on dual antiplatelet therapy | Non urgent surgery best postponed until antiplatelet therapy can be safely stopped following stenting |
| Angina | Angina only during strenuous prolonged activity, such as digging the garden. Depends on the procedure being performed and other patient factors. Discuss with Consultant Anaesthetist. | Any other Angina (CCS 2-4*) Angina at rest Angina associated with poor functional status | |
| Heart failure | No symptoms or limitation of ordinary activity NYHA class 1 | Symptomatic heart failure (NYHA class 2-4*) | Patients with heart failure having urgent minor surgery may be appropriate for day case surgery |
| Cardiomyopathy | | Cardiomyopathy | Cardiomyopathy may be asymptomatic but this is not predictive of risk. These patients are at increased risk and may be affected by arrhythmias. |
| Dysrhythmia | 1st degree heart block (rate >50bpm) Rate controlled atrial fibrillation <90bpm | Any other dysrhythmia Asymptomatic bi-fasicular or tri-fasicular heart blocks Ventricular bigeminy/trigeminy | Poorly controlled AF can become faster postoperatively preventing day case surgery. Asymptomatic tri-fasicular heart |

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| | Must be discussed with Anaesthetist | | block should be discussed preoperatively with cardiology with a view to pacing (either pre or post operatively) |
| Peripheral vascular disease | Good exercise tolerance >4 METS | Poor exercise tolerance and restricted functional ability | |
| Aortic aneurysm | AAA under surveillance <5cm Discuss with Anaesthetist | Awaiting AAA repair Intra-abdominal AAA over 5cms | An AAA of 5.5cms has a rupture rate of only 2-3% per annum although there is anecdotal evidence that the risk of rupture increases after major surgery. |
| Respiratory | | | |
| Acute Respiratory infection | | Acute respiratory infection | |
| Asthma | Stable well controlled asthma Good functional ability with no symptoms of wheeze or SOB on exertion – Asymptomatic | Chest infection within 6 weeks (i.e. from date of antibiotic course completion) should be discussed with preoperative anaesthetist. ITU admission due to asthma attack within last 12months Oral steroid course completed for asthma within 6 weeks Normal activities extremely limited by asthma | Patients with stable and well controlled asthma are often better managed as day case due to minimal disruption to their daily routine. If there is a history of brittle asthma with exacerbations from anaesthesia these patients may benefit from a night of postoperative observation. |
| COPD | Stable well controlled COPD Good functional status METS >4 Alert Anaesthetist and add alert to ORMIS | SOB rest or on minimal exertion Oxygen therapy at home Cor pulmonale | Spirometry does not necessarily correlate with postoperative outcome, but may be helpful for those patients who have no previous spirometry done or who are on suboptimal/no |

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| Obstructive sleep apnoea | <p>Patients with the following STOPBANG scores must be discussed with the Anaesthetist</p> <p>http://www.stopbang.ca/osa/screening.php On line calculator</p> <p>OSA - Intermediate Risk: Yes to 3-4 questions</p> <p><i>Modified from Chung F et al. Anesthesiology 2008; 108: 812-821, Chung F et al Br J Anaesth 2012; 108: 768-775, Chung F et al J Clin Sleep Med Sept 2014</i></p> | <p>Oral steroids within 6 weeks</p> <p>Procedure is moderate with need for significant IV morphine or postoperative opioids</p> <p>Poor compliance with CPAP (AHI over 30 at latest review) Resting SpO2 on air are under 94%</p> <p>Presence of non-optimised comorbidities (i.e. hypertension, arrhythmias, heart failure)</p> <p>Operation which might prevent the use of CPAP mask post op e.g. nasal septoplasty, necessitates overnight stay</p> <p>Patients with the following STOPBANG scores must be discussed with the Anaesthetist with a plan for referral for further assessment</p> <p>http://www.stopbang.ca/osa/screening.php On line calculator</p> <p>OSA - High Risk:</p> <ul style="list-style-type: none"> • Yes to 5 - 8 questions Yes to 2 or more of 4 STOP questions + male gender • Yes to 2 or more of 4 STOP questions + BMI >35kg/m • Yes to 2 or more of STOP questions + neck circumference 16 inches / 40cm <p><i>Modified from</i></p> | <p>treatment</p> <p>Operating in the morning enables clearance of sedative drugs medical led discharge. SAMBA guidance from 20125 recommends that patients with known OSA can be considered for day case surgery if they have and are able to use CPAP after surgery and have any co-morbidities optimised.</p> <p>Low saturations may indicate higher risk of nocturnal hypoxia.</p> |
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| | | <i>Chung F et al. Anesthesiology 2008; 108: 812-821, Chung F et al Br J Anaesth 2012; 108: 768-775, Chung F et al J Clin Sleep Med Sept 2014</i> | |
| Chronic Respiratory Conditions | Well controlled, stable Cystic Fibrosis Pulmonary fibrosis with stable symptoms and reasonable functional ability METS >4 Alert Anaesthetist and add alert to ORMIS | Cystic Fibrosis with moderate/severe disease or multisystem involvement. Symptomatic bronchiectasis with chest infection within 6 weeks of surgery Pulmonary fibrosis causing extreme limitation of everyday activities | Day surgery may be feasible in patients with stable disease and good baseline functional status. These patients must be discussed with the POA consultant and multidisciplinary team. Patients with advanced Cystic Fibrosis are usually better managed in a regional centre |
| COVID | | | <i>See UHL Alliance criterion</i> |
| Neurological / Neuromuscular | | | |
| Epilepsy | Grand Mal Seizure more than 12 weeks before planned surgery Partial seizures | Grand mal Seizure within 12 weeks of planned surgery History of status epilepticus Nocturnal seizures | Patients with epilepsy are at increased risk for postoperative complications (i.e. seizure) and therefore it is important to ensure that seizure control is optimised before surgery |

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| TIA/CVA | More than 6 months – If completely recovered or minimal disability. Discuss with Anaesthetist in consideration of functional status and residual symptoms | TIA /CVA within the last 6 months | |
| Parkinson's Disease | Good functional status discuss with Anaesthetist | Poor functional status Requires significant assistance with activities of daily living Impaired swallow Cognitive impairment Deterioration or relapse after previous anaesthetic | Impaired swallow may put Parkinson's patients at risk of postoperative respiratory complications. Cognitive impairment predisposes to postoperative delirium. |
| Multiple Sclerosis | Good functional status Minimal weakness Discuss with Anaesthetist | Patients with severe restrictions due to MS, poor swallow, speech difficulties MS with reduced mobility and active symptoms Deterioration or relapse after previous anaesthetic | Patients with MS who have weakness may have an unpredictable response to neuromuscular blocking agents. |
| Muscular Dystrophy / Myasthenia Gravis / Myotonic Dystrophy / Motor Neurone Disease | | Muscular Dystrophy Myasthenia Gravis Myotonic Dystrophy Motor Neurone Disease | |
| Metabolic | | | |

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| Diabetes | Only likely to miss one meal Insulin controlled DM – LA only Non-insulin controlled diabetes HbA1c < 69mmol/mol (8.5%) https://cpoc.org.uk/guidelines-resources-guidelines-resources/guideline-diabetes | Likely to miss more than one meal HbA1c >69mmol/mol (8.5%) or if on an insulin pump/CSII (continuous subcutaneous <i>insulin</i> infusion) Demonstrably poor blood sugar control on day of surgery, i.e. blood sugar under 4 or over 15mmol/L (these patients are likely to require CVRII which precludes day case surgery) | Blood sugars should ideally be maintained at between 6-12 mmol/L on the day of surgery meaning that demonstration of good control (as per HbA1C) is important. |
| Liver disease | | Abnormal coagulation Known cirrhosis and severe liver disease | |
| Renal disease | Stable renal failure eGFR 30mls/minute or above | CKD Stage 4-5 (i.e. eGFR below 30) CKD associated with hyperkalaemia Patients on renal dialysis | Patients who are on dialysis may be suitable for day surgery if they are compliant with their dialysis programme and have a clear plan for pre and post procedure dialysis. Discuss patients with abnormal U&Es require discussion with Anaesthetist |
| Thyroid disease | Abnormal TSH and normal T4 Asymptomatic and treated thyroid disease | Discuss other abnormalities with Consultant Anaesthetist | |
| Musculoskeletal | | | |
| Rheumatoid arthritis | Pain free movement of cervical spine (extension & flexion) Good functional ability | Severely restricted functional ability | The presence of atlanto-axial subluxation may mandate an awake intubation to reduce risk of cervical myelopathy Consider mobility and patient |

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| | | | positioning during and after surgery – Transfer from bed to trolley, and lithotomy |
| Arthritis | | Severe arthritis of jaw, neck or hips | Consider mobility and patient positioning during and after surgery – Transfer from bed to trolley, and lithotomy |
| Cervical spondylosis | Pain free and unrestricted movement of cervical spine (extension and flexion) | Severe spondylosis | |
| Haematological | | | |
| Anaemia | Treated Anaemia and Hb > 100 Discuss with Anaesthetist if between 90-100 undergoing an investigative procedure. | Patients with anaemia previously investigated and treated: Hb < 100g / L for surgery e.g. hernia repair Hb < 90g / L for investigative procedure e.g. hysteroscopy If surgery is routine and non-urgent (i.e. non cancer case) patient should be referred to the GP for investigation and treatment of anaemia. | Anaemia is associated with adverse outcomes after surgery. In addition anaemia may be a marker for underlying disease, therefore anaemic patients should be referred on for further investigation. Where the surgery is related to the cause of the anaemia it is often appropriate to proceed as a method of 'treating' the anaemia. |
| Sickle cell disease | Sickle Cell Trait – Short procedure and without risk of dehydration | History of sickle cell crisis | |
| Bleeding or coagulation disorder | Disorders other than Haemophilia should be discussed with the surgeon and anaesthetist. A haematological opinion and perioperative plan should be sort | Haemophilia | |
| Anaesthetic | | | |

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| Anaesthetic history | | Personal or family history of <ul style="list-style-type: none"> • Personal or family history (not investigated) Suxamethonium (Scoline) Apnoea or Malignant Hyperpyrexia History of: • Difficult Intubation • Severe post-operative nausea and vomiting (PONV score 4) • Difficult Spinal or Epidural Anaesthetic • Awareness During Anaesthesia • Anaphylaxis | |
| Medicines and allergies | | | |
| Monoamine oxidase inhibitors | | Patients prescribed Monoamine oxidase inhibitors | |
| Anticoagulants and Antiplatelet agents | Patients prescribed DOAC (Direct oral anticoagulants) Add alert to ORMIS | Patients prescribed Warfarin | |
| Lithium | Patients prescribed Lithium – Lithium levels to be checked and discussed with Anaesthetist Add alert to ORMIS | | Non-steroidal anti-inflammatory drugs (NSAIDs) analgesia contraindicated. |
| Latex | Non-anaphylactic history of latex allergy acceptable – 1 st on list | Allergy to Latex with a history of anaphylaxis | First on the operating list |
| Other | | | |

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| Drug Dependence | <p>Patients on a Methadone programme with no other illicit drug use. Prioritise on theatre list where possible.</p> <p>Alert Anaesthetist and add alert on ORMIS</p> | Narcotic dependence | Advise patient to continue with medication – do not miss a dose |
| Mental health | <p><i>Acute</i> mental health concerns should be discussed with the Anaesthetist to ensure that appropriate level of care and support care be provided within the Alliance</p> | | |
| Alcohol misuse and dependence | <p>Alcohol intake of less than 50 units per week without any LFT derangement.</p> <p>Without symptoms of alcohol dependence - https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684828/Fast_alcohol_use_screening_test_FAST_.pdf</p> <p>Discuss with Anaesthetist</p> | <p>Alcohol intake above 70 units or above 50 units with LFT or clotting derangement any patient with cirrhosis, any patient who cannot stop drinking without anxiety and any patient who has a history of alcoholic related seizures and is currently drinking.</p> | <p>Patients drinking over 70 units are at risk of perioperative complications or alcohol withdrawal which means they are not always suitable for day case surgery.</p> |
| Patients under investigation for another condition other than the presenting condition for surgery | | <p>All patients listed for elective surgery should have a diagnosis confirmed or excluded for any neuro, metabolic, CVS or RS. Decision on results will fall in the criteria listed above.</p> | |

| New York Heart Failure Index* | Canadian Cardiovascular Society grading of angina* |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------|
| Class 1 Cardiac Disease with no symptoms and no limitation in ordinary physical activity i.e. no SOB on climbing stairs | Class 1 - Angina only during strenuous or prolonged activity. |
| Class 2 Mild symptoms (mild SOB and/or angina) and slight limitation during ordinary activity | Class 2 – Slight limitation with angina only during vigorous physical activity. |
| Class 3 Marked limitation in activity due to symptoms, even during less than ordinary activity (i.e. walking short distances <50m). Comfortable only at rest | Class 3 Symptoms with everyday living activities, i.e. moderate limitation. |
| Class 4 Severe limitations. Experiences symptoms even while at rest. Mostly bedbound patients. | Class 4 Inability to perform any activity without angina or angina at rest i.e. severe limitation |

4. Education and Training

The POA RNs work to a guidance issued locally within the Alliance and a call with the RNs will be completed on ratification to meet any learning requirements.

5. Monitoring and Audit Criteria

| Key Performance Indicator | Method of Assessment | Frequency | Lead |
|----------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|-----------------|
| On the day cancellations | Monitoring of on the day cancellations due to inappropriate listing within the Alliance | Monthly reporting although more frequently as required | Matron Alliance |
| Clinical incident reporting | Review of clinical incident reporting in relation to delayed discharge, transfers out resulting from inappropriate listing for surgery within the Alliance | Within the time frames outlined in UHL Policy for Datix | Matron Alliance |

6. Legal Liability Guideline Statement

See section 6.4 of the UHL Policy for Policies for details of the Trust Legal Liability statement for Guidance documents

7. Supporting Documents and Key References

1. Verma R, Alladi R, Jackson I, et al. Day case and short stay surgery: 2, Anaesthesia 2011; 66: pages 417-434
This guideline can be viewed online via the following URL: <http://onlinelibrary.wiley.com/doi/10.1111/j.1365-2044.2011.06651.x/pdf>
2. Raja MH et al. The Impact of High BMI on Outcomes after Day Case Laparoscopic Cholecystectomy: A United Kingdom University Hospital Experience. AMBULATORY SURGERY 23.4 DECEMBER 2017
3. Association of Anaesthetists of Great Britain and Ireland. The measurement of adult blood pressure and management of hypertension before elective surgery 2016. Anaesthesia 2016; 71: 326-337. This guideline can be viewed online via the following URL: <http://onlinelibrary.wiley.com/doi/10.1111/anae.13348/full>
4. Qaseem A et al. Risk assessment for and strategies to reduce perioperative pulmonary complications for patients undergoing non-cardiothoracic surgery: a guideline from the American College of Physicians. Ann Intern Med 2006 Apr 18 144(8) 575-80
5. Society for Ambulatory Anesthesia Consensus Statement on Preoperative Selection of Adult Patients with Obstructive Sleep Apnoea Scheduled for Ambulatory Surgery Anesth Analg. 2012 Nov;115(5):1060-8

8. Key Words

List of words, phrases that may be used by staff searching for the Policy on SharePoint:

- *Alliance*
- *Criterion*
- *Criteria*
- *Anaesthetic assessment*
- *Pre-assessment*
- *Pre-operative assessment*

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This table is used to track the development and approval and dissemination of the document and any changes made on revised / reviewed versions

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