ACT Government | Canberra Health Services

Model of Service

Perioperative Services

July 2023

Contents

Approvals

Position	Name	Signature	Date
Executive Director, Surgery	Lisa Gilmore		

Document version history

Version	Issue date	Issued by	Issued to	Reason for issue
2.0	19/05/23	Leanne Done, Senior Change Specialist, Campus Modernisation	Perioperative Service Operation Readiness User Group (ORUG)	Draft review and feedback
2.1	25/05/23	Leanne Done, Senior Change Specialist, Campus Modernisation	Perioperative Service Operation Readiness User Group (ORUG)	Review identified section from feedback
2.2	30/05/23	Leanne Done, Senior Change Specialist, Campus Modernisation	Vanessa Brady, Executive Group Manager, Campus Modernisation	Approval to proceed to Lisa Gilmore, Executive Directory Surgery
2.3	04/07/2023	Kritika Toraskar, Client Liaison Officer, Campus Modernisation	Lisa Gilmore, Executive Director Surgery	Approval to proceed to consultation

1. Introduction

This Model of Service (MoS) for the Perioperative Services (PS) sets out the evidence-based framework for describing the right care, at the right time, by the right person / team and in the right location across the continuum of care. A clearly defined and articulated MoS helps ensure that all health professionals are 'viewing the same picture', working towards common goals and most importantly evaluating performance on an agreed basis.

This MoS:

- outlines the principles, benefits and challenges of each PS Models of Care
- provides the basis for how we deliver evidence-based care.
- contains information of patient/client flows (the areas from where patients enter and exit the service) and service co-ordination.

2. Principle

Our vision and role reflect what we want our health service to stand for, to be known for and to deliver every day. The vision and role are more than just words - they are our promise to each other, to our patients and their families and to the community. We all have a role to play in delivering on the promise:

- Vision: Creating exceptional health care together
- Role: To be a health service that is trusted by our community.

Our values:

- We are reliable - we always do what we say we'll do.
- We are progressive - we embrace innovation.
- We are respectful - we value everyone.
- We are kind - we make everyone feel welcome and safe.

CHS is committed to fostering an environment of inclusion, respect, and diversity. We recognise the uniqueness of every individual, regardless of their race, ethnicity, gender, age, sexual orientation, religion, disability, or socio-economic background. Together, we aim to adopt informed, flexible and adaptive practices which foster a culture of respectful and therapeutic relationships.

Our **Strategic Plan** sets out our path forward as an organisation for the next three years. It is values driven—it outlines how we will deliver against our vision of 'creating exceptional health care together' for our consumers, their families, and carers.

Our **Partnering with Consumers Framework** provides clear principles for a shared understanding of our approach and what is required from all team members for effective partnerships with consumers and carers in line with our organisational values. The principles have been developed in collaboration with our consumer and carer organisations and underpin this Framework.

In addition to the organisation values, this Model of Service is founded on the following service principles. They will guide our work and how we deliver services for patients/clients and families accessing care in the Perioperative Unit.

Our service principles:

Stream Models of Care - The PS Models of Care are underpinned by streamlined patient pathways that enable appropriate care and treatment in the most suitable environment.

Shared Organisational Goals - The organisation has shared goals and responsibility for achieving National Elective Surgery Targets and access to timely emergency surgery.

Access to treatment - The PS operates 24 hours a day, 365 days a year.
Education and Training - The PS has a strong focus on education, training and research programs through structured positions and portfolios.

Clinical Leadership and Expertise - The PS Leadership team support clinicians through effective communication, clinical expertise, role modeling and commitment to excellence.

Evidence informed best practice and continuous quality evaluation - The PS will use data, evidence, research, and consumer feedback to inform best practice and quality evaluation.

Preparation for Surgical Procedures and Interventions - Optimise and support the management of patient's perioperative risk through pre procedure/ intervention preparation related to the patient's planned procedure/intervention and anaesthesia.

3. Description of Service

The PS at the Canberra Hospital is a Level 5 - 6 clinical service, providing care for adult and paediatric patients who require unplanned or planned, surgical or interventional procedures. Services are provided in Building 5, Building 12, and Building 25.

Key features of the PS include:

- Enhanced clinical capability through the provision of 16 digital, four hybrid and two interventional radiology theatres.
- Streaming for patients with a disability and/or sensory considerations to enable collaborative, patient-focused, sensitive and safe care.
- A fully integrated unit with preoperative, intraoperative, and postoperative services for the management of patients requiring Day Surgery, Extended Day Surgery and Day of Surgery Admissions.
- A dedicated Neurostimulation Therapy Suite is located in Building 25 with the Adult Mental Health Unit (AMHU) that provides enhanced opportunities for people experiencing mental illness to gain access to specialised therapy.

3.1 Surgery Categories and Clinical Priority

Surgery and procedural interventions (surgical activity) may be classified as emergency, non-elective and elective surgery.

3.2 Emergency Surgery

Emergency surgery refers to cases that require operative care to treat trauma or acute illness following an emergency presentation, unplanned surgery for admitted patients or unplanned surgery for patients already awaiting an elective surgery procedure.

Emergency Surgery Clinical Priority Categories and timeframes for each category are outlined in Table 1 (based on the NSW emergency surgery guidelines and principles for improvement).

Table 1. Emergency Clinical Priority Category

Category	Clinical indication	Time - within
1	Life threatening	1 hour
2	Organ threatening	4 hours
3	Non-critical but emergency	8 hours
4	Non-critical, non-emergent but urgent	24 hours
5	Subacute	Between 24 to 72 hours

3.3 Non-Elective Surgery

Non-elective surgery is planned surgical activity (other surgery) that cannot be defined as emergency or elective surgery. These cases are considered suitable to be deferred and are not defined as elective surgery (e.g., dental, organ retrieval and planned obstetric procedures).

3.4 Elective Surgery

Elective surgery refers to planned surgery following a specialist appointment and subsequent referral to the elective surgery waiting list. Patients added to the elective surgery list will be assigned a clinical priority urgency category depending on the needs of their condition. Clinical priority urgency categories are based on the clinical assessment of the treating clinician and recommended timeframes for surgery in alignment with the National Elective Surgery Urgency Category Guidelines (NESUCG) (Table 2).

Table 2. National Elective Surgery Urgency Category Guidelines

Category	Clinically indicated within
1	30 days
2	90 days
3	365 days

3.5 Caesarean Births

Planned caesarean births are recommended when there is an identified risk to mother and/or foetus and are classified as non-elective for reporting purposes. It involves the decision to have a caesarean birth prior to the onset of either labour or unexpected complications requiring urgent delivery.

An unplanned (emergency) caesarean section may be required if complications develop and delivery needs to be quick, either during or before labour The decision to perform an emergency caesarean section is made based on a clinical risk assessment and is prioritised according to clinical indications and in line with Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) recommendations. Table 3 indicates the emergency Caesarean Clinical Priority Categories and timeframes for each category.

Table 3. Caesarean Clinical Priority Category

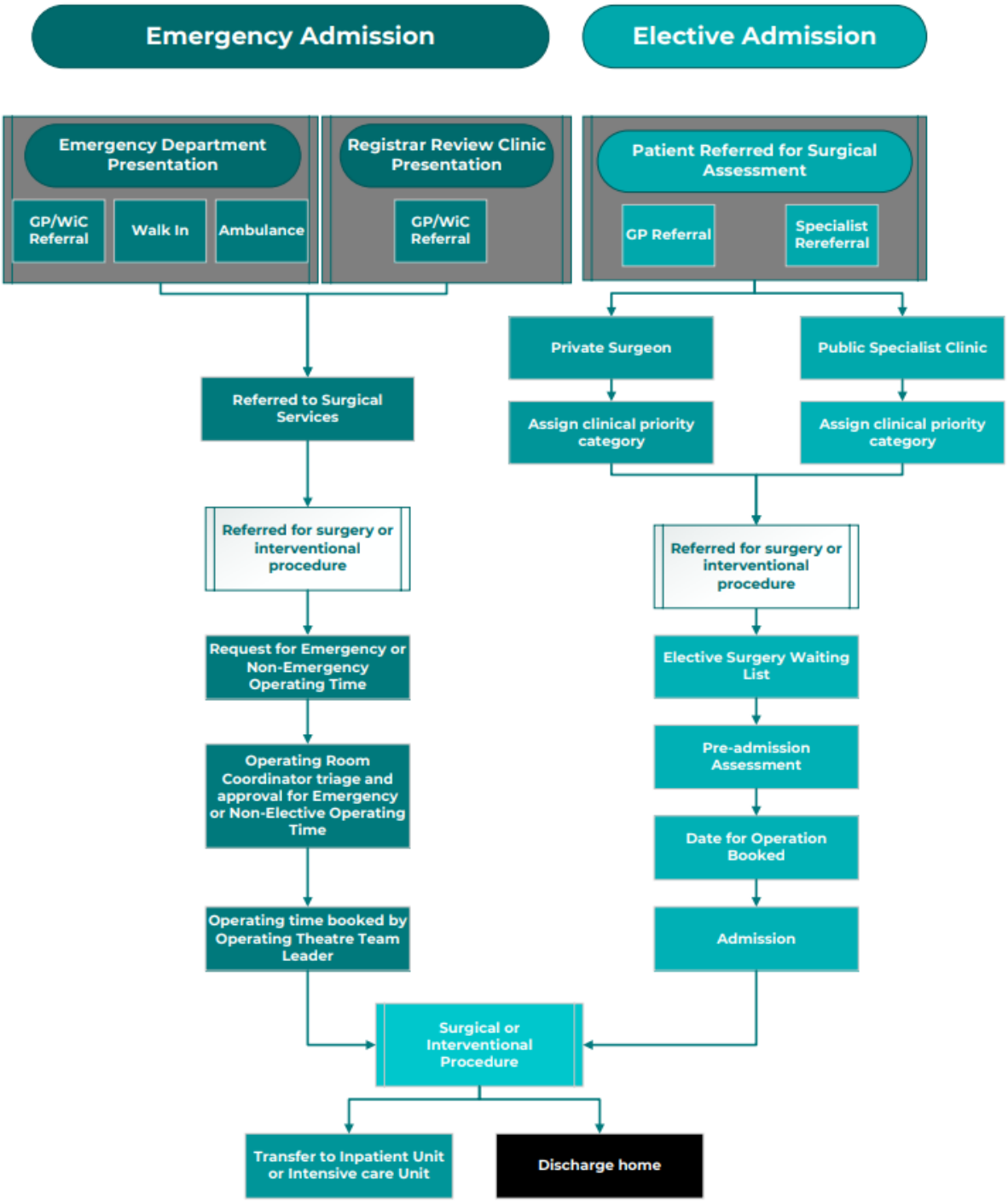
Category	Clinical indication	Delivery within
A	Mother or foetus in immediate risk of loss of life	30 minutes
B	Life threatening cases requiring urgent access to the next available theatre	60 minutes
C	No maternal or foetal compromise but needs early delivery	6 hours
D	No maternal or foetal compromise but needs delivery and cannot wait until the next available planned caesarean list	Time to suit operating and delivery suite.

4. Perioperative Services Models of Care and Patient Journey

The PS Models of Care outline patient care and streaming from arrival into PS through to discharge and transfer from PS. Models of Care are provided in accordance with the Australian College of Perioperative Room Nurse (ACORN) Guidelines and Australian and New Zealand College of Anaesthetists (ANZCA) Guidelines.

The perioperative Models of Care include streaming through preoperative, intraoperative, and postoperative phases. The PS Models of Care provide a clear understanding of how care is provided across the PS patient journey. Elective, emergency and non-elective surgical procedures follow a parallel patient pathway from the pre-operative phase to discharge or transfer to an inpatient unit, see Figure 1.

Figure 1: Emergency and elective admission process



Non-elective patients may commence their patient journey via an elective or emergency pathway including inpatients.

The Models of Care included in the Perioperative Services Model of Service include:

- Surgical Bookings and Preadmission
- Emergency Surgery
- Elective Surgery
- Holding
- Intraoperative
- Post Anesthetic Care
- Extended Day Surgery
- Paediatric Day Stay
- Post Surgery Pick Up
- Neurostimulation Therapy - Anaesthetics
- Organ Retrieval - Operating Theatres

4.1 Surgical Bookings and Pre-admission

Model of Care Principles	
Description	**Surgical Bookings** The Surgical Bookings Team are responsible for managing, planning and scheduling patients on to the elective surgery waiting list. This includes all surgical specialties who are listed on the elective surgery waiting list (ESWL). Patients are scheduled for elective surgery according to the identified clinical need assessed by the surgeon. The Elective Surgery Liaison Nurse (ESLN) coordinates surgical bookings based on clinical urgency, wait time and surgeon requests. The ESLN determines preadmission clinical requirements for attendance to the preadmission clinic.

Model of Care Principles	
	Preadmission Clinic Preadmission assessment occurs: • once a patient has been placed onto the elective surgery waiting list, prior to surgery occurring. • at the request of the surgeon to determine a patient's fitness for surgery. The pre-admission clinic assesses a patient's current health status and readiness for elective surgery, their anaesthetic risk and works to optimise patient's health status prior to their surgery. The clinic also provides an opportunity for patients to ask questions related to their procedure. **Prehabilitation** Some patients may require physical and psychological optimisation prior to surgical procedures or interventions. Planned surgery enables implementation of multidisciplinary evidence based perioperative care and protocols that enhance post operative recovery. Prehabilitation is initiated in the preadmission phase to provide a comprehensive, multidisciplinary, patient-centred assessment prior to elective surgery. Selected adult patient cohorts may be suitable for the '*Enhanced Recovery After Surgery (ERAS)*' care plan.
Principles	**Surgical Bookings** • Active management of patients waiting for elective surgery. • Best practice in elective surgery waiting list management. **Preadmission:** • First point of contact when the patient is preparing for surgery. • Assess patients' health care needs for the planned procedure or operation.

Model of Care Principles	
	• Ensure patients are fully informed regarding the intended procedure. • Discharge checks completed to enable a successful discharge. • Ensure patients are prepared for surgery and that it is safe to proceed with surgery. **Prehabilitation** • Optimise patient outcomes. • Lowering the patient's stress response to surgery. • Optimise the patient's physiological function. • Facilitate a swift and uncomplicated recovery.
Benefits	• Ability to respond to sudden changes in clinical condition. **Surgical Bookings** • Ensures patients are treated equitably within clinically appropriate timeframes and with priority given to patients with an urgent clinical need. • Ensures the elective surgery waiting list is managed to promote the most effective use of available resources. **Preadmission** • Improve patient experience. • Optimise patient health prior to surgery. • Set post-operative expectations. • Potential to improve patient recovery time. • Reduce clinical complications and adverse outcomes. • Improve clinical outcomes. • Reduce cost of care. • Reduce length of stay.

Model of Care Principles	
Performance Indicators	• Consumer and staff feedback. • Adverse events. • Length of stay. • Improved surgical bookings in accordance with elective surgery wait list and clinical urgency category. • Increased use of ERAS protocols for prehabilitation.

4.2 Emergency Surgery

Model of Care Principles	
Description	Emergency surgery sessions are planned to accommodate surgery cases in accordance with the clinical urgency category. Emergency surgery may involve patient transfers from the Emergency Department (ED), Intensive Care Unit (ICU), inpatient units or outpatient clinics. Some referrals from the ED are discharged home and booked for day of surgery admission. Referrals from private hospitals may be booked for emergency surgery and are transferred on the day of surgery. Emergency General Surgery (EGS) patients are managed under the EGS Model of Care, all other emergency surgery patients are managed by consultants from the relevant subspecialties. The unit runs designated emergency surgery sessions as well as mixed emergency and elective sessions to maximise theatre efficiency. The Operating Room Co-Ordinator (ORC) is responsible for the emergency operation list in consultation with the responsible surgical team during business hours. The on-call consultant anaesthetist is responsible for this role after hours and on weekends.

Model of Care Principles	
	The Operating Theatre Patient Flow Coordinator and/or Team Leader will manage and prioritise patients in consultation with the ORC, according to their allocated triage category and clinical status. Patients assessed as clinical urgency category 1 and 2 emergency procedures are typically transferred directly to the patient holding bays or directly to the allocated operating theatre. Admission of these patients will have already been undertaken in the relevant clinical unit or by clerical staff within the perioperative area (e.g., in cases of urgent ambulance transfer from another facility). **Pre-operative Care:** • Assess patients presenting for surgery. • Ensure patients are fully informed and consent for surgery is completed by the treating team. Ensure patients are prepared for surgery and that it is safe to proceed with surgery.
Principles	• Provide clear communication to patients, families and carers. • Completion of the pre-operative checklist. • Emergency surgery is scheduled based on clinical urgency.
Benefits	• Reduced waiting time. • Increased flexibility for emergency management.
Performance Indicators	• Theatre utilisation. • Theatre hours to meet emergency surgery demand. • Category 1 breech deliveries

4.3 *Elective Surgery*

Model of Care Principles	
Description	Elective, or planned, surgery is scheduled in advance of a patient presenting to hospital. It can be categorised as urgent, semi-urgent or non-urgent. The PS Admissions area admits most patients presenting for elective surgery. Elective surgery admissions include: • Day surgery (DS)- patients admitted and discharged on the same day. • Extended day surgery (EDS) – discharged within 23 hours of the scheduled procedure. • Day of surgery admission (DOSA) – admitted on the day of surgery and transferred to an inpatient ward post-procedure. Day prior admissions – some procedures or individual patient needs may require admission to an inpatient unit the day prior to surgery, for monitoring and/or preoperative preparation. Pre-operative Care: • Assess patients presenting for surgery. • Ensure patients are fully informed and consent for surgery is completed by the treating team. Ensure patients are prepared for surgery and that it is safe to proceed with surgery.
Principles	• Completion of the pre-operative assessment and pre-operative checklist within the DHR
Benefits	• Clinical assessment of patients on the day of surgery. • Assessment of legal paperwork, including ensuring consent and substitute decision maker paperwork is present.

Model of Care Principles	
Performance Indicators	• On time starts • Number of elective cases performed. • Number of non-elective cases performed.

4.4 Holding

Model of Care Principles	
Description	The PS has 4 dedicated holding bays. Patients are received in the holding bay from the inpatient ward areas. Clinical handover occurs at the bedside to the anaesthetic nurse. Patients remain in the holding bay until preoperative checks are completed. The patient is escorted to the anesthetic bay outside the allocated operating theatres.
Principles	• Dedicated receiving areas for preoperative patients. • Timely transfer to operating theatres. • Patient readiness for theatres.
Benefits	• Improves theatre efficiencies. • Minimises delays between cases. • Holding bays are close to operating theatres. • Enables parallel processes.
Performance Indicators	• Cases starting on time. • Session turnaround times.

4.5 Intraoperative

Model of Care Principles	
Description	The intraoperative journey starts from the time the patient is transferred to the operating theatre, to the time of anaesthesia administration, performance of the surgical procedure until the patient is transported to the Post Anaesthetic Care Unit (PACU).

Model of Care Principles	
	Interventions involve surgical procedures performed by a range of different specialists. Prior to commencement of the procedure, Team Time Out occurs and the Surgical Safety Checklist is completed. The Anaesthetist is involved in the induction of the patient, continuously monitoring the patient's safety, comfort and vital functions, followed by extubation and emergence from anaesthesia. The Instrument/Circulating nurses consistently monitor the environment, the aseptic status of the team, sterility of the set up and instruments and are responsible for the count of accountable items. In addition to the operating theatres the Anaesthetists and Anaesthetic Nursing staff support the provision of Anaesthesia for Out of Area (OOA) procedures in remote locations within Canberra Hospital. These locations are Adult Mental Health Unit for Neurostimulation, Cardiac Catheter Lab, Gastro Unit, Brachytherapy and the Imaging Department i.e., MRI, CT and Angiography suite.
Principles	During the intraoperative phase: • Maintain strict infection prevention and control guidelines. • Provide safe administration of anaesthesia. • Maintain homeostasis. • Promote patient safety, comfort and privacy. • Collaborative team environment.
Benefits	• Evidence-based protocols • A safe environment for procedures

Model of Care Principles	
Performance Indicators	• Number of procedures performed. • Same-day postponements. • Hospital-acquired complications. • Adverse clinical events. • Re-admission to operating theatre.

4.6 Post Anaesthetic Care

Model of Care Principles	
Description	The Post Anaesthetic Care Unit (PACU) accommodates post-operative patients prior to transfer to a clinically appropriate care unit for ongoing care, treatment, and discharge. PACU patient bays are centrally located in perioperative services, to provide efficient patient flow from all digital, hybrid and interventional theatres. The unit provides care for a spectrum of services including adults, obstetrics, paediatrics, major surgery, and minor procedures. Nurses monitor emergence, perform clinical assessment, manage pain, and post operative nausea and vomiting, and provide surgery-specific monitoring and care until patients are transferred to the allocated ward.
Principles	• Established clinical protocols. • Evidence-based discharge criteria. • Patient-focused care.
Benefits	• Post-operative nurse to patient ratios dependent on the acuity of the patient. • Improved surgical outcomes.
Performance Indicators	• Bed occupancy • Adverse clinical events. • Bed block hours

4.7 Extended Day Surgery

Model of Care Principles	
Description	The Extended Day Surgery Unit (EDSU) provides post operative care for a variety of time, up to 23 hours, depending on their booking status, illness, and injury: • Day surgery patients who are discharged on the same day, up to two hours duration (Including children over the age of 14 years old). • Extended day surgery patients who require a post-operative stay, up to 23 hours (Including children over the age of 16, excluding those who need parental/carer support). • Emergency patients who require pre- and post-operative care. • Patients presenting from Medical Imaging after an angioplasty procedure who require a post-procedure stay.
Principles	• EDSU 23-hours care model. • Works to admission criteria. • Uses clinical care and discharge pathways.
Benefits	The EDSU and DSU Model of Care supports: • Reduction in Length of Stay (LOS). • Improved bed turnaround. • Reduced waiting lists. • Improved theatre management efficiencies. • Predictable access to surgical beds. • Standardised patient care with better patient outcomes. • Efficient use of hospital resources.

Model of Care Principles	
Performance Indicators	• Improved patient experience. • Improved patient flow. • Bed occupancy. • Relative Stay Index.

4.8 Paediatric Day Stay

Model of Care Principles	
Description	As per the guidelines developed by the Association for the Welfare of Children in Healthcare (AWCH), the medical and psychosocial needs of children and adolescents differ from those of adults requiring health services and as a result children and adolescents have unique vulnerabilities and patient safety risks [1-5]. Consequently, it is critical to provide separate facilities for children and adolescents in all areas of the health service where they are cared for. PS provides separate facilities for children and adolescents to ensure medical and psychosocial needs of the patient, families and/or carer are met. Paediatric patients are cared for in PS under a well child model where children have access to a play area and toys while they wait for their surgery and post-operatively. Paediatric Day Stay beds are child friendly and within a safe healthy environment for pre- and post-operative paediatric care. Elective admissions to the area for children up to the age of 13 will be scheduled by Surgical Bookings in coordination with Medical Imaging who manage MRI bookings.
Principles	• Dedicated paediatric admission and post-operative beds. • Staff members involved in the care of children have training that enables them to recognise and meet the healthcare and developmental needs of children.

Model of Care Principles	
	• Staff training in the recognition of the sick and deteriorating child. • Safety from potential risk from other patients, staff and visitors. • Safety from dangerous equipment, medications or fluids, hot water and electrical injury. • Dedicated facilities for parents/carers.
Benefits	• Separate admission and stage 2 recovery beds protected from thoroughfare of adult patients, while remaining easily observable by staff. • Paediatric waiting room with a play space to meet developmental needs and for distraction purposes. • Toilet and bathroom facilities separate from adult patients.
Performance Indicators	• Number of cases • Number of postponements

4.9 Post Surgery Pick Up

Model of Care Principles	
Description	Patients who are ready for discharge will be accommodated in the Post Surgery Pick Up area. The unit may be used for those awaiting: • Paperwork. • Discharge medications. • Transport. • One dose of intravenous antibiotics. • Review by Discharge Liaison Nurse and/or Occupational Therapist.

Model of Care Principles	
Principles	• 12 Post Surgery Patient Pick Up chairs. • Dedicated nurses following up on discharges.
Benefits	• Free up inpatient beds. • Provides visibility and nursing care until discharge.
Performance Indicators	• Improved patient flow. • Bed occupancy.

4.10 Neurostimulation Therapy - Anaesthetics

Model of Care Principles	
Description	Neurostimulation (NS) Therapy otherwise known as Electroconvulsive Therapy (ECT) is used for treatment of severe depressive illness in accordance with the Mental Health Act and CHS, '*Electroconvulsive Therapy (ECT)/Neurostimulation (NS) - Adults and Children 12 years of age and over*'. There is also evidence to support the use of ECT in the treatment of acute mania, catatonia, schizophrenia and as a long-term maintenance treatment (M–ECT) for the same indications as for acute treatment. NS can be voluntary or involuntary treatment under the Mental Health Act 2015. NS should be administered in accordance with the Royal Australian and New Zealand College of Psychiatrists professional practice guidelines for the administration of electroconvulsive therapy. NS is delivered in the Neurostimulation Therapy Suite (NSTS) located in Building 25. The NSTS recovery room meets the Australian and New Zealand College of Anaesthetists (ANZCA) Post-Anaesthesia Recovery Room requirements.

Model of Care Principles	
	Perioperative Services provides medical and nursing anaesthetic and PACU support for all NS procedures. The Anaesthetist: • conduct a physical assessment for fitness for anaesthesia. • provides induction of anesthesia, airway support, continuous physiological monitoring for the duration of the NS procedure in accordance with the ANZCA Guidelines. The Anaesthetic Nurse provides: • assistance with anaesthetic induction. • patient monitoring for the duration of the NS procedure. The PACU Nurse provides: • care and monitoring of the person immediately following the procedure. Exclusion criteria: • The Mental Health Act 2015 prohibits Neurostimulation Therapy (NST) to children under 12 years of age.
Principles	• NST may only be performed in an authorised mental health service, declared under the Mental Health Act 2015. • Anaesthetic support will be provided in accordance with the ANZCA Guidelines on Sedation and/or Analgesia for Diagnostic and Interventional Medical, Dental or Surgical Procedures.
Benefits	• Planned NS procedural list. • Access gold standard treatment. • NS can be performed in the same building as Adult Mental Health Unit minimising distance for patient transfer to NSTS.

Model of Care Principles	
	• Patient do not require transfers out of building 25 to Perioperative Service in Building 5. • Promotes best practice and optimal outcomes in terms of efficacy and safety.
Performance Indicators	• Theatre utilisation. • On time start within expected timeframe. • Compliance with legislative requirements.

4.11 Organ Retrieval

Model of Care Principles	
Description	CHS is committed to providing the community with an exceptional organ and tissue donation service. Most patients who become organ donors are admitted to the ICU with an uncertain but likely unsurvivable prognosis. All Organ Donation is managed in accordance with relevant legislation and policy requirements for organ and tissue donation. The DonateLife patient flow pathway for end-of-life care ensures timely patient transfer to PS for palliative care, withdrawal of life support and transfer to operating theatres for organ and/or tissue retrieval. Organ Donation retrieval surgery is dependent upon several factors that need to be considered when negotiating Operating Theatre (OT) time including: • donor stability, • availability of OT, • availability of retrieval teams, • family support/wishes,

Model of Care Principles	
	• recipient considerations; and • the life-saving nature of organ donation retrieval surgery. The responsibility of alerting OT and booking retrieval surgery lies with the Donation Specialist Nurse Coordinator.
Principles	• Process is performed with respect and dignity for the patient, family, and carers. • Organ and tissue donation is governed by legislation and national ethical and clinical guidelines. • Organ and tissue donation requires strict protocols reflecting best practice.
Benefits	• End-of-life care at CHS is holistic and accommodates the physical, psychosocial, and spiritual needs of the patient, and includes the exploration of possibilities for deceased organ and tissue donation. • Family and carers feel respected and cared for. • CHS acknowledges that the donation of organs and tissues is an act of altruism and human solidarity that benefits those in need and society.
Performance Indicators	• Access operating theatre time. • Compliance with legislative requirements.

5. Innovations

All operating theatres (OT), hybrid operating theatres (HOT) and interventional radiology theatres (IRT) will have specialised equipment that incorporates advanced technology.

This includes medical imaging, audio visual (AV) integration, equipment tracking technologies, ultrasound, image intensifiers, monitoring equipment, intraoperative Medical Resonance Imaging (MRI), anaesthetic workstations, cardiopulmonary bypass machines and advanced surgical systems.

5.1 Digital Operating Theatres

All OTs in Building 5 are digital operating theatres (DOT), with integrated digital systems that support current and emerging digital functionality. All DOTs are fitted with digital displays screens that integrate with the Digital Health Record (DHR) to show patient scheduling and procedural information.

Image capture devices are installed in all DOTs. Clinicians can transmit real time images, audio and visual (including images captured on radiology equipment) to other locations outside of the DOT. Surgeries or procedures can be recorded for supervision, training and development purposes.

All images, video and audio are managed in accordance with the *Health Records (Privacy Access) Act 1997*.

5.2 Hybrid Operating Theatres

Building 5 PS has HOTs with fixed angiography platforms including single and biplane systems designed to support multi-disciplinary teams in delivering real-time intra-operative guidance for complex open and minimally invasive surgery.

Building 5 PS offers a Computerised Tomography (CT) angio-HOT, with CT functionality, predominantly used in major trauma, interventional oncology and advanced neurosurgical procedures.

Access to intraoperative CT provides surgeons and interventionalist with critical CT images for real time evaluation enabling decision making during surgery and procedures.

5.3 Intraoperative Medical Resonance Imaging

Access to intraoperative Medical Resonance Imaging (MRI) provides surgeons and interventionalists with critical MRI images for real time evaluation.

An MRI room is positioned adjacent to a HOT and is used for patients who need to be scanned while under general anaesthetic with minimal movement of the patient. The MRI scanning room is designed to be a separation room from the HOT to enable simultaneous use of the MRI while the HOT is in use.

5.4 Interventional Radiology Theatres

The Interventional Radiology Theatres (IRTs) in Building 5 will accommodate minimally invasive procedures using fixed image guidance to undertake angiography for patients who require invasive intervention or specialised procedures.

5.5 Cardiac Surgery Perfusion Pendant

Within the OT designated to facilitate cardiothoracic surgery, there is an additional medical services pendant which includes medical gases and power to support perfusionists during cardiac surgery.

5.6 Anatomical Pathology

PS in Building 5 offers a dedicated pathology area in proximity to the intraoperative area to undertake urgent tissue specimens to inform surgical procedures.

Anatomical Pathologists can prepare and analyse frozen tissue sections mid-procedure, providing important pathology information to assist surgeons in making intraoperative decisions.

5.7 Command Centre

The Command Centre provides a centralised workspace for the Operating Room Co-ordinator (ORC), Operating Theatre Team Leader, Anaesthetic Team leader and Patient Flow Co-ordinator for theatres to manage, prioritise, sequence and handover the emergency and non-elective surgery operating list in accordance with the 'CHS *Operating Theatres - Management of Emergency and Non-Elective Theatres*' procedures.

5.8 Scheduling

Perioperative and interventional radiology (IR) services have operated as two separate services including list management and staff utilisation. The inclusion of IR services in Building 5 PS provides the opportunity for coordinated scheduling of patients for interventional and surgical procedure which aims to optimise efficiencies and the provision of the service.

5.9 Perioperative Patient Flow

Perioperative patient flow is enhanced by the innovative flexible patient care area located in the southwest wing of PS. During peak activity the design of Building 5 enables flexibility of workflow and patient movement in the pre and post operative phases of care.

5.10 Patient Pick Up Lounge

Patients who are ready for discharge will be accommodated in the patient pick up lounge area to await pre-arranged transport.

6. Interdependencies

Interdependencies describes the internal and external functional relationships with other clinical services that specifically enable this MoS.

6.1 Territory Wide Surgical Services

Territory Wide Surgical Services (TWSS) are responsible for the governance of all ACT elective surgery delivery across ACT public hospitals and contracted care under the Public in Private program. Case requests in DHR or Requests for Admission (RFA) are assessed on an individual basis against the *'CHS Elective Surgery Access, Policy'*.

6.2 Surgical Bookings and Pre-Admission Clinic

Surgical Bookings and the Pre-Admission Clinic provide an integral service for efficient scheduling and patient bookings. Surgical Bookings manage and coordinate the elective and non-elective operating theatre sessions (excluding emergency sessions) in PS. Patients on the elective surgery waiting list are scheduled according to clinical priority. The surgical booking team contact patients to confirm the scheduled surgery date.

The Pre-Admission Clinic assesses a patient's current health status, readiness for elective surgery, anaesthetic risk and communicate issues to clinical teams with the view to optimise health prior to surgery.

6.3 Sterilising Services Unit

PS have a direct interdependency with the Sterilising Services Unit (SSU). Reusable Medical Devices (RMD) and loan sets used for surgery and procedures are reprocessed and sterilised in the SSU.

Preparation for reprocessing of RMD commences at the 'point of use' by perioperative staff, prior to transfer to the SSU in Building 5 - in accordance with the Australian College of Perioperative Nurses (ACORN) standards and Standards Australia AS/NZS 4187.

The SSU design promotes unidirectional flow for RMD reprocessing from PS to the SSU.

6.4 Intensive Care Unit

The Intensive Care Unit (ICU) is a separate and self-contained area of the hospital, dedicated to the management and monitoring of patients with life-threatening illnesses, injuries, and complications.

It provides specialised expertise and facilities for support of vital organ function through the skills of medical, nursing, allied health and other personnel experienced in complex clinical patient management.

Admission from PS to the ICU may be planned as part of a patient's post operative pathway or occur following an intra or post-operative consultation between the surgical team and an ICU specialist.

Management of critically ill patients transitioning between PS and ICU is a complex and dynamic process. Clinical communication is critical during this transition and is managed in accordance with the *'CHS, Clinical Handover, Procedure'*.

PS work collaboratively with ICU and DonateLife for withdrawal of life support for organ and or tissue donations.

6.5 Endoscopy Procedure Suite

The Building 5 PS includes emergency and elective endoscopy and urology procedures requiring anaesthetic support, due to the risk profile of the patient (e.g., bariatric patients, patients with multiple comorbidities, paediatric patients etc.).

Endoscopy and bronchoscopy procedures deemed low complexity will continue to be provided in the endoscopy procedure suite in Building 12.

6.6 Medical Emergency Team

CHS has a dedicated Medical Emergency Team (MET) that responds to all code blue emergencies. The MET provides acute resuscitation for deteriorating patients across the CH campus, who unexpectedly experience a medical emergency, including within the PS.

Due to the complex nature of medical emergencies in the perioperative environment, the MET members are appropriately trained to ensure perioperative protocols and processes are followed whilst responding to MET calls.

6.7 Healthcare Technology Management

As medical technology, equipment and innovations continue to advance, biomedical engineering and technical support is increasingly important for complex care areas such as PS.

The Healthcare Technology Management (HTM) team provide biomedical engineering, technical support, and expert advice to PS to ensure safe, quality patient care, by maintaining international best practice. As equipment becomes increasingly technical and complex, there is a growing need for services and equipment to be maintained by the vendors and HTM.

HTM assists with various agreements and contractual arrangements with vendors relating to medical devices, equipment and ICT systems used within PS.

6.8 *Procurement*

The Procurement Services team provide support and advice to PS when acquiring medical equipment, services, and supplies. This team ensures all procurement activities are completed in accordance with relevant legislation, policies, and ACT Government processes.

6.8 *Product Consultants*

Product consultants and representatives provide information and support to the PS team in relation to medical equipment, products, and services.

Support may be provided to the surgical teams in the form of product or equipment demonstration, training, education and intraoperative onsite support for specialised products, equipment, and devices used within PS.

6.9 *Supply Services*

PS uses a high volume of medical and other consumable items and products which are ordered and delivered by Supply Services.

Supply Services provide regular stock orders of inventory stock, replenishment of storerooms and assist with non-inventory orders as required.

7. Workforce

The PS workforce is managed in accordance with the:

- Relevant Enterprise Agreements
- ACTPS Work Level Standards
- Public Sector Management Act (1994)
- Public Sector Management Standards 2016
- Health Act 1993
- ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework
- ACORN
- Nursing and Midwifery to Patient ratios

The PS workforce is summarised in Table 4.

Table 4: Workforce Categories

Category	Role
Medical	• Clinical Directors • Medical Officers • Registrars • Senior Resident Medical Officers • Career Medical Officer • Interns
Nursing	• Assistant Director of Nursing • Nurse Managers • Clinical Nurse Consultants • Perioperative Nurse Educator • Patient Flow Co-Ordinator - Theatres • Resource Manager – Theatres • Resource officers • Theatre Team Leader • Clinical Development Nurses • Registered Nurses (Levels 1, 2 and 3) • Enrolled Nurses
Allied Health	• Cardiac Perfusionists • Radiographers
Support Staff	• Administration staff • Ward Clerks • Wardspersons • ISS • Hospital Assistants

Student and educators that are external to CHS, participate in PS for hospital placement experience or are part of CHS providing education and training roles. It should be noted that the number of operating rooms utilised is directly related to the demand and resources available, in providing and maintaining a safe environment.

8. Implementation

The MoS will be implemented through the following strategies:

- Orientation and training programs for new and existing staff to work within the service.
- Ongoing training programs for staff working within the service.
- Processes and documentation used within the service that support the principles of the PS Models of Care.

9. Performance and Evaluation

The PS MoS will be delivered in accordance with key government strategic performance objectives and priorities. The PS MoS supports achieving performance indicators related to PS Elective Surgery Wait List targets and quality safe patient care.

The objective for all performance improvements is to ensure patients receive quality, safe health care in 'the right care, at the right time, by the right team and in the right place'.

The PS team will evaluate its performance against:

- ACORN Standards
- ACT Health, Strategic Indicators
- ANZCA Standards
- Australian Council of Healthcare Standards (ACHS), National Safety and Quality Standards
- CHS, Strategic Indicators
- Consumer Feedback

- Elective Surgery Wait List Indicators.

PS will ensure the provision of high-quality service through ongoing feedback from patients, families and carers who use the service, as well as the measure of staff satisfaction and well-being.

Monitoring and evaluation of PS will occur through a range of mechanism including:

- CHS's Clinical Governance Structure and Committees.
- CHS's Risk Management Processes.
- National Safety and Quality Health Service (NSQHS) Standards Committees.

10. Definitions & Terms

Table 5 provides abbreviations and acronyms used in this document.

Table 5: Acronyms

Acronym	Meaning
ACHS	Australian Council of Healthcare Standards
ACORN	Australian College of Perioperative Nurses
ACT	Australian Capital Territory
ACTAS	Australian Capital Territory Ambulance Service
AHPEQS	Australian Hospital Patient Experience Question Set
ANZCA	Australian and New Zealand College of Anaesthetists
AS/NZS	Australian Standards/New Zealand Standards
Av	Average
AV	Audio Visual
CABG	Coronary Artery Bypass Graft
Cat	Category

Acronym	Meaning
CH	Canberra Hospital
CHS	Canberra Health Services
CHWC	Centenary Hospital for Women and Children
CRRS	Capital Region Retrieval Service
CSB	Critical Services Building
CT	Computerised Tomography
DHR	Digital Health Record
DO	Day Of
DOT	Digital Operating Theatre
ED	Emergency Department
EDO	Expected Day Of
EDSU	Extended Day Surgery Unit
HEMS	Helicopter Emergency Medical Service
HOR	Hybrid Operating Room
ICU	Intensive Care Unit
IR	Interventional Radiology
IRT	Interventional Radiology Theatre
MET	Medical Emergency Team
MoC	Model of Care
MoS	Model of Service

Acronym	Meaning
MRI	Medical Resonance Imaging
NESUCG	National Elective Surgery Urgency Category Guidelines
NOF	Neck of Femur
NSQHS	National Safety and Quality Health Service
NSW	New South Wales
OT	Operating Theatre
PACU	Post Anaesthetic Care Unit
PS	Perioperative Services
RMD	Reusable Medical Devices
SSU	Sterilising Services Unit
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RFA	Request for Admission
RMD	Reusable Medical Device
WYC	Women, Youth and Children
YTD	Year to Date

Table 6 provides term definitions used in this document.

Table 6: Terms and Definitions

Term	Definition
Guideline	Intended for CHS staff, guidelines detail the recommended practice to be followed by staff but allow some discretion or autonomy in its implementation or use. Guidelines are written when more than one option is available under a given set of circumstances, and the appropriate action requires a judgement decision. Guidelines may also be used when the supporting evidence for one or other course of action is ambiguous.
Model of Care	Model of Care describes principles for providing the right care, at the right time, by the right person/team and in the right location.
Model of Service	Model of Service describes evidence-based framework for service delivery and performance measures.
Policy	Intended for CHS staff, policy documents are an overarching, organisational wide directive about how staff are to act in defined circumstances or regarding a particular situation. Policies are documents based on legislation, Standards, regulations and/or ACT Government requirements and compliance is mandatory. A policy is often, but not always, supported by a procedure or guideline.
Procedure	Intended for CHS staff, procedures detail specific methods or actions staff must undertake to complete required processes within CHS. Procedures inform staff about how to complete clinical or administrative actions consistently across the organisation. The actions are evidence based and informed by staff who are subject matter experts. Non-compliance with a clinical procedure must be clearly documented in the patient's clinical record.

11. Reference List

ACEM, 2012 Statement on the Delineation of Emergency Departments, Doc No S12, November 2012, Version 05.

ACI, 2021, NSW Emergency Surgery Guidelines and principles for improvement, 18 May 2021, NSW Government

ACORN, 2023, Nursing Roles, Australian College of Perioperative Nurses (ACORN).

AWCH, 2008, Standard for the Care of Children and Adolescents in Health Services, Association for the Wellbeing of Children in Healthcare.

CHS Policy, Elective Surgery Access.

CHS Procedure, Day Surgery Hospital Initiated Postponement and Rescheduling of Surgery on the Elective Waiting List

CHS Procedure, Enhanced Recovery after Surgery (ERAS) (Adults only)

CHS Procedure, Operating Theatres – Management of Emergency and Non-Elective Theatres.

CHS Procedure, Photo, Video and Audio: Capture, Storage, Disposal and Use.

Health Records (Privacy and Access) Act 1997

NSW Health Guide to Role Delineation of Clinical Services, role-delineation-of-clinical-services.pdf (nsw.gov.au)

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Categorisation of urgency for caesarean section: C Obs 14: RANZCOG. 2019.

12. Model of Service Development

Participant Position
Director of Anaesthesia, Division of Surgery
Clinical Director Surgery, Division of Surgery
Visiting Medical Officer, Anaesthetist, Division of Surgery
Assistant Director of Nursing, Perioperative Services, Division of Surgery
Assistant Director of Nursing, Surgical Bookings and Pre-Admission, Division of Surgery
Director of Operations, Division of Surgery
Director of Nursing, Division of Surgery
Clinical Nurse Consultant, Extended Day Surgery Unit, Division of Surgery
Clinical Nurse Consultant, Anaesthetics, Division of Surgery
Clinical Development Nurse, Extended Day Surgery Unit, Division of Surgery
Registered Nurse, Anaesthetics, Division of Surgery
Nurse Unit Manager, scrub side, Division of Surgery
Clinical Nurse Consultant, Post Anaesthetic Care Unit, Division of Surgery
Registered Nurse, Post Anaesthetic Care Unit, Division of Surgery
Perioperative Nurse Educator, Division of Surgery
Clinical Nurse Consultant, Angiography, Division of Medicine
Acting Assistant Director of Nursing, Medical Imaging, Division of Medicine
Director of Allied Health, Medical Imaging, Division of Medicine
Radiographer, Medical Imaging, Division of Medicine
Director Procurement, Procurement and Business Support, Chief Financial Officer Group
Senior Change Specialist, Campus Modernisation
Client Liaison Officer, Campus Modernisation

ACKNOWLEDGMENT OF COUNTRY

Canberra Health Services acknowledges the Traditional Custodians of the land, the Ngunnawal people. Canberra Health Services respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. Canberra Health Services also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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