

# Introducing the Emergency Laparotomy Clinical Care Standard

The Emergency Laparotomy *Clinical Care Standard* (the Standard) was developed by the Australian Commission on Safety and Quality in Health Care in response to national and international evidence of substantial variation in care and outcomes for patients undergoing this high-risk procedure.

The Standard's development was informed by an expert topic working group and further shaped through public consultation. It builds on established quality improvement initiatives including the work of the Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) and the UK's National Emergency Laparotomy Audit (NELA).

The Standard has been endorsed by 20 organisations including:

- ANZ College of Anaesthetists
- ANZ Intensive Care Society
- ANZ Society of Geriatric Medicine
- Colorectal Surgical Society of ANZ
- General Surgeons Australia
- Royal Australasian College of Surgeons
- Rural Doctors Association of Australia
- Sepsis Australia.

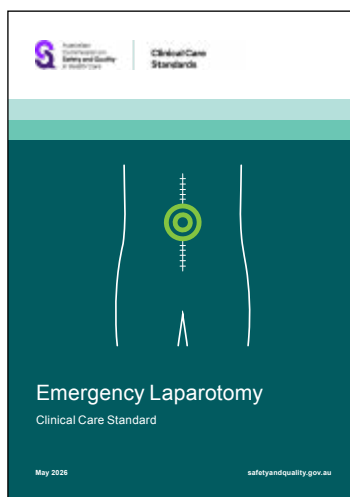
## Defining 'emergency laparotomy' for the Standard

In the Standard, 'emergency laparotomy' is used to cover a variety of emergency surgical procedures for urgent, high-risk, intra abdominal conditions, performed via open or laparoscopic approaches.

The in-scope procedures involve substantial mortality and morbidity risk; while procedures with lower mortality, such as appendicectomy and cholecystectomy, are excluded.

Trauma laparotomy is also excluded, due to the multi-system nature of emergency trauma surgery and the existence of dedicated trauma guidelines and registries.

Clinicians and health services are not precluded from applying the standard of care to patients outside the defined scope.



Download the *Emergency Laparotomy Clinical Care Standard* from the Commission's website to find out more about:

- what the statements mean for consumers, clinicians and healthcare services
- indicators to support local measurement and quality improvement
- cultural safety and equity considerations
- what the Standard says about capacity and capability, especially in regional, rural and remote Australia
- Clinical Care Standards and accreditation under the National Safety and Quality Health Service (NSQHS) Standards.



# Emergency Laparotomy Clinical Care Standard - Quality statements

## 1. Rapid assessment and escalation

A patient with symptoms suggestive of a time-critical intra-abdominal condition – including infection, perforation, bleeding, obstruction or ischaemia – is rapidly assessed and escalated in line with local protocols. If clinical assessment or initial investigations indicate the patient may need an emergency laparotomy, they are promptly referred for surgical review. In critically ill patients, investigations include blood lactate measurement.

When sepsis is suspected, care is initiated urgently in accordance with the local sepsis pathway and the Sepsis Clinical Care Standard.

## 2. Diagnostic imaging

A patient with symptoms suggestive of a time-critical intra-abdominal condition has a computed tomography (CT) scan as soon as possible, with intravenous contrast unless contraindicated. The radiologist verbally communicates critical findings to the referring or responsible clinician, within one hour of the scan being performed. Acquiring a CT scan should not delay very urgent surgery.

## 3. Assessment of risk

A patient being considered for an emergency laparotomy has their risk assessed and documented before surgery, using a validated, locally endorsed mortality risk prediction tool in addition to clinical judgement. In older patients, frailty, cognitive impairment and delirium are identified and documented preoperatively using brief, validated tools.

This information helps inform care pathways, interdisciplinary communication and discussions with patients and those supporting them.

## 4. Shared decision making and goals of care

When an emergency laparotomy is being considered, there is shared decision making about the patient's treatment plan with the patient and their family, support people or substitute decision-makers as appropriate. The patient's goals of care are discussed and documented before surgery, and updated throughout the perioperative period.

When surgery may be non-beneficial, senior doctors are involved in discussing the likely outcomes, benefits and risks of surgical and non-surgical approaches to support shared decision making.

## 5. Timely access to surgery

A patient having an emergency laparotomy commences surgery within the timeframe specified by their assigned surgical urgency category.

## 6. Presence of consultant doctors during surgery

A high-risk emergency laparotomy patient (mortality risk  $\geq 5\%$ ) has a consultant surgeon and a consultant anaesthetist present in theatre during their surgery.

## 7. Postoperative critical care

A patient's postoperative critical care needs are considered based on mortality risk, frailty, comorbidities and clinical judgement. A patient with a mortality risk  $\geq 10\%$  is discussed with a consultant intensivist for consideration of direct postoperative admission to critical care.

## 8. Proactive assessment and collaborative management of the older patient

An older patient who has an emergency laparotomy is proactively assessed and collaboratively managed by an appropriate physician, such as a geriatrician, skilled in the perioperative care of older adults. This assessment occurs as early as practicable and no later than 72 hours following presentation to hospital.

## 9. Transition from hospital care

Before a person leaves hospital following an emergency laparotomy, an individualised care plan is developed describing their ongoing care needs. The plan addresses medicines, pain management, nutrition, wound care, and other services and supports needed to optimise recovery and reduce the risk of complications.

The written plan is provided to the patient and their support people before they leave hospital. At the time of discharge, the plan is communicated to the patient's general practice, and to clinicians and other care providers involved in their ongoing care.

