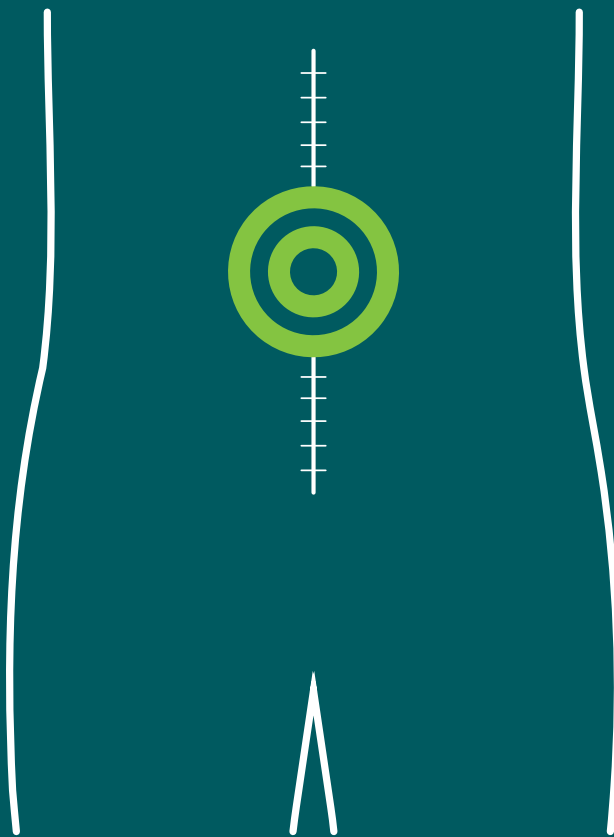




Australian
Commission on
Safety and Quality
in Health Care

Clinical Care Standards



Emergency Laparotomy

Clinical Care Standard

May 2026

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The Australian Commission on Safety and Quality in Health Care pays respect to the Gadigal people as the Traditional Custodians of Country where the Commission's office is located. We extend that respect to all Aboriginal and Torres Strait Islander peoples, and their deep time connections to land, water and sky.

We recognise that knowledge about healthy Country, community and culture has been developed by Aboriginal and Torres Strait Islander peoples over tens of thousands of years and has been shared for generations. We are committed to partnering with and learning from Aboriginal and Torres Strait Islander peoples through the work that we do.

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The *Emergency Laparotomy Clinical Care Standard* has been endorsed by the following organisations:



Australasian College
for Emergency Medicine



ANZCA
FPM



Royal Australasian
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ANZICS



ANZSGM



AAG
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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.

Indicators for local monitoring

The following indicators will support healthcare services to monitor how well they are implementing the care recommended in this Clinical Care Standard. These indicators are intended to support local quality improvement activities.

Quality statement 1. Rapid assessment and escalation

Indicator 1a: Proportion of patients who had an emergency laparotomy whose blood lactate levels were available at first surgical review.

Quality statement 2. Diagnostic imaging

Indicator 2a: Proportion of patients who had an emergency laparotomy whose computed tomography scan results were verbally communicated by a radiologist to the referring or responsible clinician, within one hour of the scan being performed.

Quality statement 3. Assessment of risk

Indicator 3a: Proportion of patients who had an emergency laparotomy whose risk was assessed using a validated mortality risk prediction tool and documented before surgery.

Indicator 3b: Proportion of patients aged 65 years or older who had an emergency laparotomy, whose frailty was assessed using a validated tool and documented before surgery.

Quality statement 4. Shared decision making and goals of care

Indicator 4a: Proportion of patients aged 65 years or older who had an emergency laparotomy, whose goals of care discussion was documented using a locally endorsed form before surgery.

Quality statement 5. Timely access to surgery

Indicator 5a: Proportion of patients who had an emergency laparotomy within the timeframe specified by their assigned surgical urgency category.

Quality statement 6. Presence of consultant doctors during surgery

Indicator 6a: Proportion of patients with a pre-operative mortality risk $\geq 5\%$ who had an emergency laparotomy, where a consultant surgeon was present in theatre during surgery.

Indicator 6b: Proportion of patients with a pre-operative mortality risk $\geq 5\%$ who had an emergency laparotomy, where a consultant anaesthetist was present in theatre during surgery.

Quality statement 7. Postoperative admission to critical care

Indicator 7a: Proportion of patients with a pre-operative mortality risk $\geq 10\%$ who had an emergency laparotomy, with documentation that postoperative critical care was discussed with a consultant intensivist before surgery.

Indicator 7b: Proportion of patients who had an emergency laparotomy, who had an unplanned admission to critical care from the ward.

Quality statement 8. Proactive assessment and collaborative management of the older patient

Indicator 8a: Evidence of local arrangements that ensure older emergency laparotomy patients are proactively assessed and collaboratively managed by an appropriate physician skilled in the perioperative care of older adults.

The local arrangements should be tailored to service size and complexity and the needs of the local population and specify the processes to:

- ensure older people who are undergoing emergency laparotomy are assessed by an appropriate physician within 72 hours of presentation to hospital
- support involvement of appropriate physicians in the collaborative management of older emergency laparotomy patients
- support implementation and monitoring of the local arrangements.

Indicator 8b: Proportion of patients aged 65 years or older who had an emergency laparotomy, who were assessed within 72 hours of hospital presentation by an appropriate physician.

Quality statement 9. Transition from hospital care

Indicator 9a: Evidence of local arrangements for the development of a written individualised care plan for emergency laparotomy patients before discharge from hospital.

The local arrangements should specify the:

- process to involve the patient and their family or support people in development of the care plan
- process to ensure input from multidisciplinary team members in the development of the care plan, when needed
- information that should be documented in the patient's care plan
- process to ensure that the care plan is provided to the patient and directly to their regular clinicians and care providers, including their nominated general practitioner or other primary healthcare provider, at the time of discharge from hospital
- process for addressing the specific needs of patients who were transferred out of their local area for surgery or rehabilitation
- process to support implementation and monitoring of the local arrangements.

Indicator 9b: Proportion of patients who had an emergency laparotomy, whose discharge summary was sent to their nominated primary healthcare provider at the time of discharge from the hospital.

Overall indicators

Indicator 10a: Proportion of patients who had an emergency laparotomy, who had an unplanned readmission to any hospital within 30 days of discharge.

Indicator 10b: Proportion of patients who had an emergency laparotomy who died within 30 days of their surgery.

Indicator 10c: Proportion of patients who had an emergency laparotomy who died within 90 days of their surgery.

More information

The definitions required to collect and calculate indicator data are specified online at the Australian Institute of Health and Welfare's Metadata Online Registry (METEOR): meteor.aihw.gov.au/content/818241.

Also see the [Using indicators](#) section for more information.

Clinical Care Standards

A Clinical Care Standard describes the care that patients should be offered by clinicians and healthcare services for a specific clinical condition, treatment, procedure or clinical pathway, regardless of where people are treated in Australia. Clinical Care Standards aim to address unwarranted variation in health care or patient outcomes by increasing evidence-based health care for priority aspects of care.

Clinical Care Standards include:

- quality statements that describe the expected standard for key components of patient care
- explanations of what each quality statement means for
 - patients – so that people receiving care know what care may be offered and can make informed decisions in partnership with their clinician
 - clinicians – to support decisions about appropriate care
 - healthcare services – to inform them of the policies, procedures, and organisational factors that can enable the delivery of high-quality care
- indicators to support local quality improvement, allowing clinicians and healthcare services to monitor the care described in the Standard.

Clinical Care Standards are developed by the Australian Commission on Safety and Quality in Health Care (the Commission). By working in partnership with the Australian Government, states and territories, the private sector, clinical experts, and patients and carers, the Commission aims to ensure that the health system is better informed, supported and organised to deliver safe and high-quality care.

Applying Clinical Care Standards

While implementation of the *Emergency Laparotomy Clinical Care Standard* is not mandated, healthcare services assessed to the National Safety and Quality Health Service (NSQHS) Standards are expected to identify relevant Clinical Care Standards and implement those that will reduce risk to patients, improve quality, and address local areas of unwarranted variation in process or outcomes, or from best practice, according to their local quality improvement priorities.

The Commission's [Fact Sheet: Applicability of Clinical Care Standards](#) provides more information about assessment to the NSQHS Standards, compliance and the role of indicators.

For information about applying the Standard in different settings, see the [Healthcare settings](#) section.

General principles of care

Clinical Care Standards should be implemented as part of an overall approach to improving safety, quality, and appropriateness of care. Some principles and key actions are described in other Commission standards and guidance and are not reproduced here. These include:

- [effective clinical governance](#)
- [person-centred care and partnering with consumers](#)
- [shared decision making and informed consent](#)
- [environmental sustainability and climate resilience](#)
- cultural safety and equity (see also [Cultural safety and equity](#) on page 13).

National Safety and Quality Standards

Clinical Care Standards support quality improvement and can be used in any setting where they may help achieve high-quality care. Information about the role of Clinical Care Standards for healthcare services providing care consistent with the [National Safety and Quality Health Service Standards](#)¹ and the [National Safety and Quality Primary and Community Healthcare Standards \(Primary and Community Healthcare Standards\)](#)² can be found online.

For more information, see:

- [NSQHS Standards](#)¹
- [National Safety and Quality Primary and Community Healthcare Standards](#)²
- [Fact Sheet: Applicability of Clinical Care Standards](#)³
- [User Guide for Reviewing Clinical Variation](#)
- [Clinical Care Standards](#)
- [Joint Statement on Climate Change and Health](#).⁴

About the Emergency Laparotomy Clinical Care Standard

Goals

The goals of this Clinical Care Standard are to:

- optimise outcomes for patients having an emergency laparotomy, including survival, quality of life and functional independence
- ensure high-quality and timely assessment, diagnosis and management of patients undergoing emergency laparotomy
- support good practice in decision making about treatment, consistent with the patient's preferences, values and goals of care.

Scope

The Standard relates to the care that patients aged 18 and over should receive when they may need an emergency laparotomy (see definition in [Defining 'emergency laparotomy'](#)). This includes patients for whom surgery is indicated but who do not go on to have surgery. It applies from first presentation to an emergency care setting (or first recognition of deterioration on the ward) with a potentially time-critical abdominal condition, through to discharge planning and transition to primary and community care.

What is not covered

The Standard does not cover:

- trauma laparotomy
- emergency appendicectomy or cholecystectomy
- vascular surgery including abdominal aortic aneurysm repair
- primary gynaecological or urological emergency procedures.

While patients under 18 years are not in scope for this Standard, it is recognised that patients between 16 and 18 years are able to make decisions and give consent to medical treatment in certain circumstances. Health services may choose to apply this Standard to patients under 18 years (mature minors) who are making decisions about their care when this is necessary and appropriate.

Defining ‘emergency laparotomy’

The term ‘emergency laparotomy’ is used in this Standard – and related programs such as the Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) – to collectively describe a variety of emergency surgical procedures for urgent, high-risk, intra-abdominal conditions, performed via open or laparoscopic approaches.

The included procedures present a substantial risk of mortality and serious morbidity, and it is on this basis that more common procedures with significantly lower mortality, such as appendectomy and cholecystectomy, are excluded.

Trauma laparotomy is also excluded. This is consistent with other national and international emergency laparotomy programs and registries and acknowledges the multi-system nature of emergency trauma surgery and the existence of current trauma guidelines and registries. Likewise, vascular, gynaecological and urological emergency procedures are excluded as they follow distinct clinical pathways and require specific clinical expertise. Emergency laparotomy for bowel complications of earlier surgery in these specialties is included.

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

Perioperative care

Perioperative medicine and its role in contemporary surgical care is evolving in Australia and internationally. The Australian and New Zealand College of Anaesthetists (ANZCA), in collaboration with other key colleges and societies, has developed [A framework for perioperative care in Australia and New Zealand](#) and the framework’s principles have helped inform the development of the Emergency Laparotomy Clinical Care Standard.^{5,6} Key terms defined in the framework include:

- **perioperative care:** the multidisciplinary, individualised, integrated care of patients, from the moment surgery is contemplated through to their optimal outcome
- **perioperative care team:** all the individuals who may be involved in a patient’s perioperative journey such as doctors, nurses, physiotherapists and other allied health professionals, as well as family members or other carers
- **perioperative medicine:** the science and practice of working with patients from the moment surgery is contemplated, to optimise their health and wellbeing, minimise the risk of perioperative complications, and facilitate optimal recovery, underpinned by shared decision making.

Healthcare settings

This Clinical Care Standard applies primarily to the care provided in public and private hospitals with the capability to carry out emergency laparotomy surgery. Aspects of the Standard may also be relevant to the care provided in hospitals and healthcare settings that do not have the capability to perform emergency laparotomy on-site but that provide emergency care and play a crucial role in ensuring timely access to surgical review. See [Box 1](#) for discussion of how the Standard applies in regional, rural and remote settings.

The quality statements in this Clinical Care Standard may not be applicable to every healthcare service or clinical unit. Services should consider their individual circumstances when determining how to apply each statement.

When implementing this Clinical Care Standard, healthcare services should consider:

- the context in which care is provided
- local variation
- quality improvement priorities of the individual healthcare service.

Box 1: Regional, rural and remote settings

It is acknowledged that hospitals in rural and regional Australia which provide emergency laparotomy care vary considerably in their capacity and capability to perform emergency surgery and provide perioperative care. For services in these settings, interpretation and application of the Clinical Care Standard must reflect local circumstances and prioritise the best interests of individual patients. These services are encouraged to consider how relevant quality statements can be implemented locally in line with the goals of the Clinical Care Standard and the purpose of the quality statement.

This Standard outlines priority components of care to improve processes and outcomes for all patients requiring emergency laparotomy, regardless of where they live. Its intent is not to prevent or discourage the provision of emergency laparotomy in rural and regional settings where a service is equipped and supported to do so, and where this is clinically appropriate. Many services in these settings have established processes and workforce arrangements to enable the delivery of high-quality emergency laparotomy, including systems for transferring high-risk patients, subject to appropriate risk-benefit analysis, to an appropriate location for treatment and/or postoperative critical care.

When considering implementation of the Clinical Care Standard in these settings, services may consider additional strategies, such as strengthening links with referral hospitals and retrieval services, the use of hub-and-spoke models linking larger and smaller health services, and the use of telehealth.

It is also acknowledged that some regional, rural and remote services that would not normally conduct emergency laparotomy surgery may need to provide aspects of care in exceptional circumstances.

Evidence

Key sources that underpin the Standard include the following current clinical guidance:

- Enhanced Recovery After Surgery (ERAS) Society Guidelines, including the following guidelines for emergency laparotomy:
 - [Part 1 – Preoperative: Diagnosis, Rapid Assessment and Optimization](#)⁷
 - [Part 2 – Emergency Laparotomy: Intra- and Postoperative Care](#)⁸
 - [Part 3 – Organizational Aspects and General Considerations for Management of the Emergency Laparotomy Patient](#)⁹
- Royal College of Surgeons of England (RCS) 2018 report, [The High-Risk General Surgical Patient: Raising the Standard](#)¹⁰
- National Emergency Laparotomy Audit (NELA) standards, indicators and reports including the [Ninth Patient Report](#)¹¹
- Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) [standards, key performance indicators and annual reports](#).¹²

See the Commission's [Emergency Laparotomy Clinical Care Standard](#) webpage for a full list of the evidence sources that support this Clinical Care Standard.

Supporting resources

See the Commission's [Emergency Laparotomy Clinical Care Standard](#) webpage for supporting documents, including the following.

- Guide for consumers
- Information for clinicians
- Information for healthcare services
- Links to other resources, templates and information.

Using indicators

Measurement is a key part of quality improvement. The indicators in this Clinical Care Standard allow clinicians and healthcare services to monitor and improve the care they provide as part of local quality improvement activities.

When using the indicators, note the following.

- Indicators are listed with the related quality statement.
- The Commission does not set benchmarks for the Clinical Care Standard indicators.
- Services may use other relevant measures that relate to their needs and the needs of their patients in addition to, or instead of, these indicators. See also information on [Australian and New Zealand Emergency Laparotomy Audit - Quality Improvement \(ANZELA-QI\)](#).

The specifications for each indicator are described in METEOR: Metadata Online Registry. These define how to collect and calculate indicator data and describe the applicable healthcare settings.

Indicators from other Clinical Care Standards can also support monitoring including those listed below.

- *Sepsis Clinical Care Standard*: definitions required to collect and calculate indicator data are available online at meteor.aihw.gov.au/content/755589.
- *Delirium Clinical Care Standard*: definitions required to collect and calculate indicator data are available online at meteor.aihw.gov.au/content/745804.

Indicators to support overall monitoring

These indicators are recommended to support monitoring of the care described across this Clinical Care Standard to support improvement at multiple levels of the health system. Where routine access to linked datasets is available, the following outcome indicators are recommended:

Indicator 10a: Proportion of patients who had an emergency laparotomy, who had an unplanned readmission to any hospital within 30 days of discharge.

METEOR link: meteor.aihw.gov.au/content/818277

Indicator 10b: Proportion of patients who had an emergency laparotomy who died within 30 days of their surgery.

METEOR link: meteor.aihw.gov.au/content/818279

Indicator 10c: Proportion of patients who had an emergency laparotomy who died within 90 days of their surgery.

METEOR link: meteor.aihw.gov.au/content/818281

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

These clinical outcome indicators can be complemented by data on the impact of emergency laparotomy on patients' quality of life after surgery. See the Commission's website for more information on [clinical quality registries](#) and quality measures, including [patient-reported outcome measures](#) and [patient experience measures](#).

Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI)

ANZELA-QI is a clinical quality registry providing feedback to participating hospitals on key evidence-based indicators of emergency laparotomy care, enabling them to assess their performance, monitor variation and drive quality improvement.

ANZELA-QI commenced in 2018, supported by the Royal Australasian College of Surgeons (RACS) and other key colleges and societies. It was modelled on the United Kingdom's (UK) [National Emergency Laparotomy Audit \(NELA\)](#) which has been credited with substantial improvements in emergency laparotomy outcomes, including a reduction in mortality across the UK from 11.8% to 8.1% in its first 10 years.

This Clinical Care Standard and ANZELA-QI indicators align where possible. Healthcare services that perform emergency laparotomies are encouraged to participate in the registry.

For more information on ANZELA-QI, see [ANZ Emergency Laparotomy Audit – Quality Improvement](#) (RACS).

Cultural safety and equity

Person-centred care recognises and respects differences in individual needs, beliefs and culture. The Commission:

- is committed to supporting healthcare services to provide culturally safe and equitable health care to all Australians
- acknowledges that discrimination and inequity are significant barriers to achieving high-quality health outcomes for some patients from culturally and linguistically diverse communities.

Culturally safe service provision and environments are those where the places, people, policies and practices foster mutual respect, shared decision making, and an understanding of cultural, linguistic and spiritual perspectives and differences. Cultural safety is supported by organisations and individuals that recognise cultural power imbalances and actively address them by:

- ensuring access to and use of interpreter services or cultural translators when this will assist the patient and aligns with their wishes
- providing visual or written information in a language that the patient, their family and carers will understand
- providing cultural competency training for all staff
- encouraging clinicians to review their own beliefs and attitudes when treating and communicating with patients¹³
- identifying variation in healthcare provision or outcomes for specific patient populations, including those based on ethnicity, and responding accordingly.¹⁴



Cultural safety and equity for Aboriginal and Torres Strait Islander peoples

Health outcomes for Aboriginal and Torres Strait Islander peoples can be improved by addressing systemic racism and other root causes that reduce access to care. Historical and current contributing factors include a lack of culturally safe care, culturally appropriate health education, and sociocultural determinants such as differences in employment opportunities.

The considerations for improving cultural safety and equity in this Clinical Care Standard focus primarily on overcoming cultural power imbalances and improving outcomes for Aboriginal and Torres Strait Islander peoples through better access to health care.¹⁵

Cultural safety and equity recommendations in this document have been developed in consultation with Aboriginal and Torres Strait Islander individuals, clinicians and representative health service organisations. However, it is recognised that cultural safety is determined by the Aboriginal and Torres Strait Islander individuals, families and communities experiencing the care.¹⁶

Recommendations

When implementing this Clinical Care Standard, cultural safety can be improved through embedding an organisational approach, such as described in the recommendations below. Specific considerations for cultural safety for people undergoing emergency laparotomy are provided throughout this Standard.

When providing care for Aboriginal and Torres Strait Islander people, particular consideration should be given to the following recommendations.

Building culturally safe systems

- Ensure systems and processes support people to self-report their Aboriginal and Torres Strait Islander status and to record self-identification.
- Ensure all staff engage regularly in cultural safety training.
- Implement the [six actions](#) for Aboriginal and Torres Strait Islander Health from the NSQHS Standards.¹³

Flexible and connected service delivery

- Provide flexible service delivery to optimise attendance and help develop trust with Aboriginal and Torres Strait Islander people and communities.
- Establish robust communication channels and referral pathways with primary healthcare providers (including Aboriginal Community Controlled Health Organisations [ACCHOs]).
- Where possible, provide outreach services close to home, on Country or in collaboration with ACCHOs or other community healthcare providers.

Communication and person-centred care

- Take a collaborative approach to ensure that interventions are suitably tailored to the individual's personal needs and preferences for care.
- Encourage the inclusion of support people, family and kin or the person's trusted healthcare provider (such as their ACCHO) in all aspects of care, including decision making and planning treatment and management.
- Engage culturally appropriate interpreter services and cultural translators when this will assist the patient.
- Involve Aboriginal and Torres Strait Islander Health Workers or Aboriginal and Torres Strait Islander Health Practitioners as part of a patient's multidisciplinary team and involve Aboriginal and Torres Strait Islander Liaison Officers in hospital settings.
- Use culturally and linguistically appropriate materials to aid in communication and discussion, accounting for varying levels of health literacy.

Related resources

- [NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health](#) – a guide to help improve the quality of care and health outcomes for Aboriginal and Torres Strait Islander people based on the National Safety and Quality Health Service Standards¹³
- [National Agreement on Closing the Gap](#) – an agreement built around [four priority reforms](#) for transforming the way governments work with, and for, Aboriginal and Torres Strait Islander peoples to improve outcomes
- [Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health](#) – a framework that commits the Australian Government and all states and territories to embed cultural respect principles into their health systems¹⁵
- [Clinical Yarning](#) – a patient-centred framework to improve communication in Aboriginal health care¹⁷
- [Communicating Positively: A Guide to Appropriate Aboriginal Terminology](#) – a guide developed by NSW Health to use when working with Aboriginal people and communities, and when developing policy and programs¹⁸
- [Plain English Health Dictionary](#) – a resource developed by the Northern Territory Government as a resource for Aboriginal Interpreter Services¹⁹

Emergency laparotomy

Each year, more than 15,000 Australians undergo an emergency laparotomy (emergency abdominal surgery on the gastrointestinal tract) for time-critical conditions such as intra-abdominal infection, bowel obstruction, perforation, internal bleeding and ischaemia.²⁰

Emergency laparotomy is a high-risk procedure with mortality estimates in Australia ranging from 6.2% to more than 20% in older adults and people with comorbidities.^{21,22} Extended hospital stays and postoperative complications such as infection and pneumonia are common.^{21,23} Many patients will experience poor functional outcomes and loss of independence following hospitalisation for an emergency laparotomy.^{7,24-26} The financial burden associated with the procedure is also significant at an estimated cost to Australian hospitals of around \$400 million per year.²⁰

More than half of patients who have an emergency laparotomy are aged over 65, and many of these older patients have a high level of frailty and multiple age-related comorbidities. More than 20% of emergency laparotomy patients have sepsis on presentation.^{21,26,27} Patients in both these groups are at particularly high-risk of poor outcomes following an emergency laparotomy.

Aboriginal and Torres Strait Islander Australians are twice as likely to be admitted for emergency surgery as non-Indigenous Australians.²⁸ They are also more likely to experience chronic health conditions that can complicate recovery, often at a younger age.²⁹

In rural and remote Australia, for patients with time-critical intra-abdominal conditions, access to appropriate investigations and treatment can be limited. Transfer is clinically and logistically complex, often involving long distances and delaying time to surgery.

International and Australian evidence shows that a structured approach to the care of patients undergoing emergency laparotomy can substantially improve outcomes. Key components of care found to have driven improved outcomes include timely recognition and treatment of sepsis, pre-operative assessment of mortality risk and frailty, planned postoperative critical care for high-risk patients, and geriatrician involvement in the care of older patients.^{9-11,21}

Shared decision making and meaningful, patient-centred discussions about goals of care and limitations on medical treatment are also important elements of high-quality care, especially for high-risk patients for whom surgery may offer limited benefit in terms of survival or quality of life.

Australian data from ANZELA-QI have demonstrated considerable inter-hospital variation in care and highlighted the potential for quality improvement approaches to drive improved care processes and outcomes. Notable findings include the following.³⁰

- Although 74% of patients undergoing emergency laparotomy were assigned a surgical urgency of 18 hours or less, just 59% of these patients arrived in theatre within the appropriate timeframe.³¹
- Only 22% of older patients were assessed postoperatively by a geriatric medicine specialist or team, despite evidence that such reviews are associated with lower mortality.^{31,32}
- Around 64% of highest-risk patients were admitted to an intensive care or high dependency unit postoperatively, even though direct admission to critical care following surgery is known to support earlier recognition and management of postoperative complications.^{23,31}

There is a clear opportunity for timely, appropriate and standardised processes and pathways of care to drive improved outcomes – including survival and post-surgery quality of life – for patients undergoing emergency laparotomy in Australia.

Quality statements

Quality statement 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*.

Purpose

To ensure that a patient with a potentially time-critical intra-abdominal condition, including sepsis, is identified early and their further assessment and treatment is expedited appropriately.

What the quality statement means

For patients

A laparotomy is a major operation where a long incision (cut) is made in the abdomen (tummy) to carry out surgery. An emergency laparotomy is done for urgent and possibly life-threatening conditions such as:

- a hole in the bowel (perforation)
- a blockage of the bowel (obstruction)
- significant internal bleeding
- reduced blood flow to the intestines (a serious condition called ischaemic bowel)
- an infection in the abdomen
- sepsis (a life-threatening condition that can occur in response to infection – see [Related resources](#) for more information about sepsis).

If your symptoms mean you could have one of these conditions, you might need urgent surgery. You will need to be examined and have some tests as quickly as possible. Based on your test results, you may need to see a surgeon immediately to help decide on the most suitable treatment for you.

If you are showing signs of sepsis, your treatment for this should begin immediately. Treatment for sepsis usually involves fluids and medicines (such as antibiotics) being given directly into your veins through a drip. It may also include surgery to control the infection. Timely treatment is essential to prevent complications from sepsis.

For clinicians

While acute abdominal presentations are common and often due to non-critical and self-limiting conditions, mortality and morbidity increase with delayed recognition and treatment of time-critical intra-abdominal conditions such as:

- perforation
- ischaemia
- bleeding
- bowel obstruction
- infection and/or sepsis.^{10,33}

Whether patients with symptoms suggestive of such time-critical conditions present to an emergency setting or deteriorate on a ward, the same approach applies.

- Prioritise rapid assessment and escalate in line with local protocols, ensuring the appropriate involvement of senior clinicians.⁷ Clinical assessment and escalation will often occur simultaneously with resuscitation, diagnostic investigations and optimisation for surgery.^{9,34}
- Consider sepsis when symptoms could indicate an intra-abdominal infection.
- When sepsis is suspected, expedite assessment and treatment in line with the local sepsis pathway and the *Sepsis Clinical Care Standard*. This includes (but is not limited to) use of an appropriate clinical decision support tool, measurement of blood lactate, taking of blood cultures, timely administration of appropriate antimicrobials, and prioritisation of surgical source control.^{7,35}
- Seek surgical review without delay if clinical assessment and/or investigations suggest a possible need for urgent surgery. In critically unwell patients referred for surgical review, ensure that investigations include blood lactate measurement. Blood lactate is an independent predictor of mortality for emergency laparotomy patients and is valuable in decision making about surgery.³⁶ (See [Quality statement 3](#) for more information on assessment of risk.)
- Do not delay surgical referral or review due to pending investigations or while awaiting investigation results.

If transfer would be required to access time-critical investigations and/or treatment, rapidly escalate to senior clinicians, noting that transfer or retrieval may not be appropriate in some cases, with such exceptions identified based on a risk-benefit analysis. See [Box 2](#) for further discussion about transfer, including from regional, rural and remote settings.

Maintain a high index of suspicion for time-critical intra-abdominal conditions and/or sepsis in patients commonly at risk of delayed diagnosis, including older patients, patients with a high degree of frailty or significant comorbidities, people with cognitive impairment, delirium or communication difficulties, and people who are immunocompromised.^{33,35}

For healthcare services

Implement protocols, procedures and pathways for patients presenting to an emergency care setting, or deteriorating on the ward, that support:

- rapid assessment and escalation of patients with symptoms suggestive of time-critical intra-abdominal conditions
- prompt referral for surgical review when assessment and/or investigations indicate a patient may need an emergency laparotomy
- appropriate investigations including blood lactate measurement for critically unwell patients being referred for surgical review (noting that pending results should not delay urgent referral or review).

Ensure that a sepsis pathway has been locally approved and implemented, and incorporates the essential elements described in the [Sepsis Clinical Care Standard](#), such as:

- triggers and timeframes for escalation of care
- guidance on time-sensitive interventions such as
 - fluid resuscitation and administration of appropriate antimicrobials
 - source control, including urgent surgical referral when required
- involvement of clinicians with experience in recognising and managing sepsis.

Provide education and training on the time-critical nature of serious intra-abdominal pathologies and the importance of early sepsis recognition and management, including source control.

In services without access to investigations or suitable treatment for serious intra-abdominal conditions, ensure that protocols, procedures and pathways support urgent escalation, shared decision making and transfer when appropriate. (See [Box 2](#) for further considerations regarding potential patient transfer.)

Measure, review and address potential sources of delay for emergency surgery patients to support continuous quality improvement.



Cultural safety and equity

Explain your concerns about the patient's condition, and the rationale for any tests and interventions in a culturally safe way to the patient and their family, support people or substitute decision makers. Allow time for explanation and questions.

Consider the cultural safety [Recommendations](#), including those related to communication and person-centred care, including:

- ensuring a collaborative approach tailored to the individual's personal needs and preferences for care
- involving support people, family and kin in decision making, and when planning treatment and management
- using culturally and linguistically appropriate materials to support communication, accounting for varying levels of health literacy
- engaging interpreters and cultural translators when this will assist the patient
- involving Aboriginal and/or Torres Strait Islander Health Workers, Health Practitioners or Liaison Officers as appropriate and if this is what the patient wants.

Some patients may need to be transferred away from home or Country to access treatment.

- Ensure the patient's values and preferences are considered during shared decision making about transfer. Family, culture and connection to Country may be important considerations for patients, which should be acknowledged.
- Arrange for a patient being transferred to have access to adequate support and advocacy while in hospital away from home. Involve Aboriginal and/or Torres Strait Islander Health Workers, Health Practitioners or Liaison Officers, if this is what the patient wants.^{35,37}

Related resources

- [What is sepsis?](#) (Sepsis Australia)
- [Sepsis Clinical Care Standard](#) (Australian Commission on Safety and Quality in Health Care, 2022)
- [Fact sheet: Lactate in the deteriorating patient and sepsis](#) (Australian Commission on Safety and Quality in Health Care, 2022)

Indicator for local monitoring

Indicator 1a: Proportion of patients who had an emergency laparotomy whose blood lactate levels were available at first surgical review.

METEOR link: meteor.aihw.gov.au/content/818244

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Box 2: Transfers and the potential emergency laparotomy patient

For patients with acute abdominal symptoms who may require emergency laparotomy, transfers are a major source of risk, often delaying time-critical care and surgery. A transfer may be considered when access is required for:

- a CT scan or other diagnostic investigations
- surgery, including expertise appropriate to the patient's condition and risk
- critical care including postoperative admission for the high-risk patient.

In some cases, transfer may not be possible or appropriate, or may need to be deferred. The urgency of treatment or source control may necessitate that the emergency laparotomy be performed on-site, with transfer afterwards for further intervention and critical care. A risk-benefit analysis must consider factors such as the stability of the patient and urgency of their condition, the time involved in the earliest possible transfer or retrieval, and the patient's goals, values and preferences.

When considering transfer

- Escalate decision making about transfers to senior clinicians within the originating service. Seek advice and support for clinical decision making, as needed, from the relevant tertiary or other receiving hospital, or retrieval service as appropriate. This should be a consultant-to-consultant peer discussion, and involve multidisciplinary input as needed. If there is no consultant at the originating service, involve the most senior clinician responsible for the patient.
- Assess the patient's risk (informed by their mortality risk score, if possible, in addition to comorbidities, frailty and clinical judgement) to help inform decision making about transfer and pathways including the need for postoperative admission to critical care. (See [Quality statement 3.](#))
- Discuss what is involved, and the risks and benefits of transfer, with the patient and their support people or substitute decision makers to enable informed, shared decision making. Discussions should include, as appropriate, the risk of experiencing serious complications, the possibility of losing independence or dying away from home, and the likelihood of admission to intensive care. Recognise that transfer may be inconsistent with some patients' goals, preferences or cultural needs; discuss alternative procedures or medical management options as appropriate, which may include palliative and supportive care. (See [Quality statement 4.](#))
- When considering the appropriate transfer destination, aim to send the patient to a facility where they can access all diagnostic and treatment needs without further transfer. Give early consideration to the most appropriate hospital location for the patient's care following surgery or Intensive Care Unit (ICU), which may be their local hospital.

When a decision has been made to transfer a patient

Before transfer, ensure there is discussion between senior clinicians, ideally consultants, within the referring facility and receiving facility, and retrieval service if relevant. The referring and receiving facilities should document relevant discussions, decisions and care plans in the patient's healthcare record.

Ensure that goals of care and limitations on medical treatment have been discussed and are documented in the patient's transfer notes.

Rural and remote health services

While many transfers for emergency laparotomy occur between metropolitan hospitals, transfers from rural and remote facilities are common and further complicated by issues such as distance, time, transportation, loss of continuity of care, and separation from family and community support.^{38,39}

The networks and systems required to facilitate timely, appropriate care for patients in these settings are challenging, complex, diverse and resource-intensive. Local processes and pathways – including strong connections with tertiary hospitals and retrieval services – are essential to support timely, patient-centred decision making, coordinated transfer for patients who may need an emergency laparotomy, and appropriate interventions before and during transfer.

Related resources

[Critically ill patient transport 2025](#) (ACEM, ANZCA, CICM).

Quality statement 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.

Purpose

To ensure appropriate, timely diagnostic imaging is available to support diagnosis and decision making.

What the quality statement means

For patients

If there is a chance you have a condition that might need an emergency laparotomy, you will have a CT scan as soon as possible.

A CT scan uses a combination of X-rays and computer technology to make detailed pictures of the inside of your body. The pictures from the CT scan help your doctors see what is happening in your abdomen so they can plan the right treatment.

During your scan, you might be given a dye called 'contrast material' that helps show more detail in your CT scan pictures. The dye will be given directly into your vein through a drip.

A radiologist will review your CT scan and quickly provide the results to your healthcare team.

If you need extremely urgent surgery, it may be better to have your operation straight away rather than delay it to have a CT scan.

If CT scanning is not available where you are, you may be transferred to another service for your scan. Your healthcare team will talk to you and your support people about what this involves.

For clinicians

CT with intravenous (IV) contrast is the optimal imaging to assist with accurate diagnosis and determine appropriate management for the patient who may require emergency laparotomy.^{7,40} Be aware of current guidance for the use of contrast media in renal impairment: do not delay emergency imaging requiring IV contrast in order to obtain renal function testing results.⁴⁰⁻⁴²

For referring clinicians

Refer the patient with acute abdominal symptoms suggestive of a time-critical intra-abdominal condition as soon as possible for CT, with IV contrast unless contraindicated. Seek radiology advice if there is any uncertainty regarding the preferred imaging, and for any patient who is pregnant.

Communicate the urgency of the referral, and that the patient may need an emergency laparotomy, to ensure it is prioritised.

Ensure that accessing CT or awaiting results does not delay very urgent surgery.

If the patient needs to be transferred to another facility for CT, immediately involve a senior clinician at the referring site. (See [Box 2](#) for considerations regarding transfer.)

For radiologists

Advise the referring clinician on the appropriate imaging approach for the patient as needed.

Expedite review of images and communicate critical findings within an hour of the scan for patients with suspected time-critical pathology. Communicate findings verbally to the referring and/or responsible clinician; this must be a clinician who can take appropriate clinical action. Document the discussion in the patient's medical imaging report, including who the results were discussed with. Ideally there will be discussion between the reporting radiologist and the responsible surgeon pre-operatively. Ensure ongoing availability to discuss findings with the surgeon as needed.^{43,44}

Observe local protocols regarding the required level of training for radiologists reporting on emergency abdominal CTs. Where emergency laparotomy may be indicated, review and reporting by a consultant radiologist before surgery is preferred. In some services, particularly overnight, this may be provided by a senior radiology trainee under appropriate supervision. A suitably experienced radiologist should always be available to provide advice and a second opinion as needed for less experienced radiologists.

For healthcare services

Implement policies, procedures and pathways for potential emergency laparotomy patients that ensure:

- timely and appropriate CT referral and imaging
- access to radiology advice on the appropriate imaging approach, when required
- appropriate communication of critical imaging results including timely, verbal communication of critical findings to the referring and/or responsible clinician, and discussion with the consultant surgeon as needed
- documentation of discussions about results, including who the results were discussed with
- timely availability of images to the referring and/or responsible clinician and continued access to radiology advice to discuss images when required
- clarity regarding the local scope of practice and roles and responsibilities for radiologists reporting on emergency abdominal CT.

In services where radiology reporting is outsourced, ensure that service agreements support local policies and procedures. These include the timely provision of images and reports, and access to suitably experienced radiologists to advise on test selection if required and to communicate directly about imaging results for urgent surgical cases.

Monitor, review and address potential sources of delay related to imaging for patients undergoing emergency laparotomy to support continuous quality improvement.

In hospitals where CT is not available on-site, ensure that protocols, procedures and pathways support timely escalation, shared decision making and patient transfer. (See [Box 2](#) for considerations regarding transfer.)



Cultural safety and equity

Explain how CT scanning will benefit the patient and what it involves. Involve the patient's family, support people and/or substitute decision makers in discussions. Listen and identify concerns in a culturally safe way.

Consider the cultural safety [Recommendations](#), including those related to communication and person-centred care.

Indicator for local monitoring

Indicator 2a: Proportion of patients who had an emergency laparotomy whose computed tomography scan results were verbally communicated by a radiologist to the referring or responsible clinician, within one hour of the scan being performed.

METEOR link: meteor.aihw.gov.au/content/818249

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Quality statement 3

Assessment of risk

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

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

Purpose

To ensure that patients' perioperative risk is objectively assessed to help inform appropriate pathways, facilitate interdisciplinary communication and support shared decision making.

What the quality statement means

For patients

An emergency laparotomy is a major operation to treat very serious health conditions, and so there are risks involved. Before having surgery, it is important for you, your family and support people, and your healthcare team to understand the risks.

For some people the risks are greater because of the seriousness of their condition, their age or other health needs.

If your doctors think you might need an emergency laparotomy, they will use a scoring system to help estimate the level of risk that might be involved for you. Your risk score is based on information about you and your health conditions. It helps to give your healthcare team a snapshot of your overall health and fitness for surgery which can help them plan your care with you. The score is just one piece of information your team will consider.

If the risks are greater for you because of your age, or other factors, your healthcare team will also assess the following.

- **Frailty:** This is about how strong or weak your body is. It is important to know about frailty because it can affect your risk of complications and how well you recover from surgery. Depending on how frail you are, you may need additional support and advice from your healthcare team.
- **Memory and thinking:** If you have any problems with your memory or thinking, this might increase your risk of developing delirium after surgery. Delirium involves a change in a person's thinking or behaviour. It often appears as new or increasing confusion.

All of this information will be used to help guide the care that is offered to you before, during and after surgery. It will help you, your family or substitute decision makers, and your healthcare team have discussions about your treatment and what is most important to you. For some people, this may mean deciding not to have surgery.

For clinicians

Pre-operative risk assessment for the patient who may require emergency laparotomy supports informed decision making about treatment and enables care to be planned according to risk.

Assess and document the patient's mortality risk pre-operatively using a locally endorsed, validated mortality risk prediction tool. Commonly used tools include the:

- National Emergency Laparotomy Audit (NELA) risk calculator – which has been validated for use in Australia
- American College of Surgeons' National Surgical Quality Improvement Program (ACS NSQIP) Surgical Risk Calculator
- Surgical Outcome Risk Tool (SORT).⁴⁵⁻⁴⁷

In patients aged 65 years and older – and on an individual basis for younger patients, including Aboriginal and Torres Strait Islander patients aged 45 years and above, and patients with complex healthcare needs – assess and document the following.

- **Frailty:** Use a locally endorsed, validated frailty assessment tool such as the Clinical Frailty Scale. Frailty is independently associated with higher morbidity and mortality following emergency laparotomy and is not considered in some mortality risk calculators. Patients with frailty (for example, a Clinical Frailty Scale score of 5 or greater) should be considered high-risk regardless of their calculated mortality risk.^{7,11,48,49}
- **Cognitive impairment and delirium risk** (or presence): Use a brief, validated tool such as the 4AT.⁵⁰ Perioperative delirium is associated with increased mortality, readmissions, perioperative complications and long-term cognitive decline. The presence, or risk, of delirium will affect the patient's management plan. Refer to the [Delirium Clinical Care Standard](#) for more information.

Use this information about the patient and their risk – in combination with clinical judgement – to support interdisciplinary communication, help determine care pathways such as postoperative admission to critical care, and inform important discussions with patients and their support people about treatment decisions and consent for surgery.^{7,10} Ensure the risk of complications, and functional outcomes that are inconsistent with the patient's goals of care, are also considered during decision making. (See [Quality statement 4](#) for more information about shared decision making and goals of care.)

While risk scores can help guide discussions, they should be presented as an estimate and communication should be individualised, noting that mortality risk models may over-estimate or under-estimate risk for the individual.^{7,45}

For healthcare services

Implement policies, protocols and procedures that ensure that for all patients being considered for emergency laparotomy there is:

- pre-operative assessment and documentation of mortality risk using a locally endorsed risk prediction tool in addition to clinical judgement
- pre-operative assessment and documentation of frailty, cognitive impairment and delirium for all patients aged 65 years and older – and on an individual basis for younger patients including for Aboriginal and Torres Strait Islander patients aged 45 years and older, and patients with complex healthcare needs
- consistent use of locally endorsed, appropriate tools which might include, for example, the [NELA mortality risk calculator](#), Clinical Frailty Scale and [4AT](#) for delirium
- a shared understanding of roles and responsibilities for conducting and documenting these assessments.

Ensure that the appropriate tools for local use have been agreed by clinicians and incorporated into policies and systems. Provide clinicians with targeted education and training on the use of the locally selected tools.

Where possible, embed risk tools in electronic medical record (EMR) systems to support their consistent use and facilitate ready access.

Ensure that consideration of risk is incorporated into relevant clinical processes and pathways including:

- shared decision making discussions (about treatment and/or transfer)
- postoperative admission to critical care
- involvement of geriatricians and other appropriate physicians.



Cultural safety and equity

Consider the cultural safety [Recommendations](#) relating to communication and person-centred care when discussing risk with the patient. Provide information in a way that is culturally safe and that the patient, and their support people, family and kin understand. Allow time for explanation and questions. Use plain language and visual aids where appropriate. Involve Aboriginal and/or Torres Strait Islander Health Workers, Health Practitioners, or Liaison Officers as appropriate to their role, and to the extent that the patient wishes.

Use screening and assessment tools that are culturally appropriate. The 4AT screening tool for delirium has been translated into [21 languages](#). The [Kimberley Indigenous Cognitive Assessment](#) (KICA) has been developed specifically for Indigenous Australians and includes a remote and urban version.

Related resources

- [Frailty and surgery](#) (British Geriatrics Society and the Centre for Perioperative Care)
- [Delirium: Patient information sheet](#) (NSW Health Agency for Clinical Innovation)
- [Delirium Clinical Care Standard](#) (Australian Commission on Safety and Quality in Health Care, 2021)

Indicators for local monitoring

Indicator 3a: Proportion of patients who had an emergency laparotomy whose risk was assessed using a validated mortality risk prediction tool and documented before surgery.

METEOR link: meteor.aihw.gov.au/content/818251

Indicator 3b: Proportion of patients aged 65 years or older who had an emergency laparotomy, whose frailty was assessed using a validated tool and documented before surgery.

METEOR link: meteor.aihw.gov.au/content/818253

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To ensure patients and their families, support people and substitute decision makers are supported to make appropriate and informed decisions about care, consistent with the patient's values, goals and preferences.

What the quality statement means

For patients

It is important that you are involved in decisions about your care. If emergency laparotomy is a possible treatment option, your doctors will talk with you and your family or other support people about your condition, the benefits and risks of surgery and any other options so you can decide on the care that is right for you.

Your doctors will ask about your goals, values and preferences. They will want to understand what is important to you and how your treatment options align with your wishes. These are called goals of care discussions, and they will be documented in your healthcare record. Your goals of care may change while you are in hospital. Your doctors and other members of your healthcare team will continue to talk to you and your family and support people about what is important to you.

If you are too unwell to make decisions yourself, your doctor will involve your substitute decision maker(s) in discussions about your care. A substitute decision maker is someone you have chosen to make decisions on your behalf if you are too unwell to decide for yourself. It is usually one or more trusted family members or friends. You may have legally appointed someone to take on this role, but this is not always the case. If you have an advance care plan, this can also help guide your doctors to ensure decisions about your future care are in line with your values and preferences.

In some situations, people may decide not to have an emergency laparotomy. Often this is because their condition is very serious and an emergency laparotomy may not result in a good outcome. For example, their other health issues could mean the surgery may not extend their life or could significantly reduce their independence or quality of life. If this is the case for you, a senior doctor will talk to you and your family, support people or substitute decision makers about your options, which may include choosing not to have surgery at all. Together, you can make decisions that reflect your goals and what matters most to you.

For clinicians

Shared decision making is an essential component of patient-centred perioperative care and patients should be involved in decision making about their care to the extent that they are able. When a patient is unable to participate in decisions about their care, identify and involve family, support people and substitute decision makers in accordance with the patient's expressed wishes, and state or territory legislative frameworks; access and consider the implications of any advance care planning documents.⁵¹

Ensure there is sensitive, clear and direct communication with the patient, their family and/or substitute decision makers about their clinical situation, their treatment options, and the associated risks, benefits and likely outcomes. When discussing likely outcomes, include, as appropriate, the range of possible functional and cognitive outcomes and the potential need for intensive care.⁵¹ Explore the patient's values, goals and preferences. Use structured and standardised approaches as appropriate to support meaningful, realistic discussions and decisions about treatment alternatives, such as:

- the BRAN methodology ('Benefits, Risks, Alternatives, do Nothing')⁷
- Best Case / Worst Case scenarios framework.⁵²

Risk assessment scores can help inform these discussions but must be interpreted with care and cannot be used in isolation to make treatment decisions.

Documenting goals of care supports a shared understanding between patients, their support people, and the healthcare team during the hospital admission. Goals of care assist with setting clinical expectations and articulating the values and preferred outcomes of the patient.

Particularly for patients aged 65 and above, and other patients with a high degree of complexity, frailty and/or comorbidity, ensure that:

- goals of care and limitations on medical treatment are discussed, documented and re-evaluated throughout the perioperative period
- local goals of care forms, or similar clinical directive forms, are used and readily available on the patient's healthcare record – noting that they do not replace the need for meaningful, timely discussion.⁶

When surgery may be non-beneficial or cannot realistically achieve the patient's preferred outcomes, ensure that:

- senior doctors are involved in shared decision making discussions; this should include the operating surgeon and other members of the perioperative team as appropriate such as senior anaesthetists, intensivists or perioperative physicians
- there is structured shared decision making that considers whether to proceed with an emergency laparotomy, and explores alternative procedures or medical management options, which may include palliative and supportive care, ensuring the patient's and family's final treatment choices are informed by a realistic understanding of likely outcomes
- discussions are tailored based on the patient's decision, so that
 - if the patient is proceeding with surgery, the range of possible outcomes is discussed, ensuring that the outcomes acceptable to the patient are understood and reflected in their documented goals of care and limitations on medical treatment^{5,7,9,53,54}
 - if the patient is proceeding with medical management, likely outcomes are explained, including whether surgical management will be re-evaluated
- there are referrals to appropriate services to co-ordinate ongoing treatment and support – this may include referral to palliative care for patients approaching the end of life.

For healthcare services

Implement policies, protocols and procedures that support:

- shared decision making with patients and their families and/or substitute decision makers
- discussion and consistent documentation of goals of care and limitations on medical treatment before surgery – especially for older patients and younger complex patients – and re-evaluation of these throughout the perioperative period as required
- structured, shared decision making involving senior clinicians, about proceeding with an emergency laparotomy when surgery may be non-beneficial
- access to and appropriate enactment of advance care planning documents
- the use of a locally endorsed goals of care form and ready access to the completed form on patients' healthcare records.

Provide access to structured shared decision making tools such as the BRAN methodology (Benefits, Risks, Alternatives, do Nothing), and information resources to support communication about treatment with patients and their substitute decision makers.⁵⁵

Provide access to education and training for clinicians on goals of care discussions and shared decision making strategies and skills, including communication skills to support sensitive, clear and direct discussions about risk and prognostic issues.

Define and communicate clinicians' roles and responsibilities in relation to shared decision making and goals of care. Ensure this includes the requirement for senior clinicians to be involved in shared decision making for patients where surgery may be non-beneficial.



Cultural safety and equity

Consider the cultural safety [Recommendations](#) relating to communication and person-centred care in relation to shared decision making. Provide information in a way that the patient and family understand and is culturally safe. Allow time for explanation and questions. Use plain language and visual aids where appropriate.

Recognise and accommodate the important role that family, community and connection to Country can play throughout a patient's surgical journey.^{37,56} Involve family in decision making and informed consent discussions to the extent that the patient wishes. Involve interpreters and Aboriginal and/or Torres Strait Islander Health Workers, Health Practitioners or Liaison Officers when this will benefit the patient.

Consider that cultural factors may influence who is involved in decision making. Aboriginal and Torres Strait Islander patients may require or prefer the involvement of multiple decision makers. The term 'family' may have varying meanings in different cultures; for example, family may include people who are not first-degree or second-degree relatives but culturally have a close tie to the person or are important in their culture and link to Country. These considerations may also influence who appropriate substitute decision makers are if the person does not have capacity.

Recognise that patients may have diverse and important religious beliefs or cultural practices related to surgery, ageing and traditional medicines, as well as end-of-life care and palliative care. Patients approaching end of life may prefer to die on Country. Always ask patients about their needs and preferences, and do not make assumptions about the care they should receive.^{37,51,56}

Related resources

For patients

- [What is advance care planning?](#) – Information for consumers about advance care plans and substitute decision makers (Advance Care Planning Australia, 2025)
- [Australian Charter of Healthcare Rights](#) (Australian Commission on Safety and Quality in Health Care, 2020)

For clinicians

- [Guideline for the care of patients at the end-of-life who are considered for surgery or interventional procedures](#) (Australian and New Zealand College of Anaesthetists, 2022)
- [A framework for perioperative care in Australia and New Zealand](#) (Australian and New Zealand College of Anaesthetists, 2021)
- [Identifying goals of care: tips for clinicians](#) (Australian Commission on Safety and Quality in Health Care, 2019)

Indicator for local monitoring

Indicator 4a: Proportion of patients aged 65 years or older who had an emergency laparotomy, whose goals of care discussion was documented using a locally endorsed form before surgery.

METEOR link: meteor.aihw.gov.au/content/818255

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Quality statement 5

Timely access to surgery

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

Purpose

To ensure patients undergoing emergency laparotomy receive timely surgery to optimise outcomes.

What the quality statement means

For patients

Once it is decided that you will have an emergency laparotomy, your healthcare team will aim to get you to surgery within a safe and appropriate timeframe. Your doctor will give you a surgical urgency category that helps the hospital team understand how quickly you need surgery so they can prioritise your operation appropriately.

Your doctor will communicate with the rest of your healthcare team about the urgency of your surgery to make sure everything is in place for your operation and recovery.

Depending on how serious your condition is, you may need surgery very quickly. If you could have sepsis, it is always important to act fast.

For clinicians

Delay to surgical intervention for patients requiring emergency laparotomy is associated with increased mortality and morbidity, particularly in patients with sepsis. Triage, investigations and diagnosis, optimisation for surgery and inter-facility transfer all affect the timeliness of surgery.

To help minimise unwarranted delay between the decision to operate and the commencement of surgery:

- assign a surgical urgency category in accordance with the local framework, to support the appropriate differentiation of urgency and prioritisation of theatre access
- communicate with the perioperative team about the urgency of surgery and the need for post-operative critical care when appropriate
- document the date and time of the decision to operate in the patient's healthcare record to enable accurate calculation of timely theatre access
- follow local escalation protocols if issues arise such as conflicts regarding surgical prioritisation, theatre access or decision making about transfers.^{57,58}

For patients being transferred to another facility for surgery, a surgical urgency category is typically assigned by the receiving hospital. Time-critical management and transfer by the referring clinician are essential in reducing delays to surgery. Further considerations for the patient who needs to be transferred for surgery are outlined in [Box 2](#).

For patients with an intra-abdominal source of sepsis, mortality rises with every hour of delay.^{59,60} Recognise and respond to the urgent need for source control for patients with a confirmed or suspected intra-abdominal source of sepsis and prioritise their surgery accordingly. Guidelines recommend that patients with septic shock receive surgical source control as soon as possible and within three hours. Patients with sepsis without septic shock should receive surgical source control within six hours.^{7,10}

For healthcare services

In hospitals that perform emergency laparotomy the following recommendations apply.

- Consider the targeted strategies needed locally to optimise theatre utilisation and workforce capacity.
- Ensure that theatre access and resourcing support timely surgery for patients requiring an emergency laparotomy in accordance with their clinical need and assigned surgical urgency category. Systems should support the prioritisation of critically ill patients for emergency surgery before patients receiving non-critical or elective surgery.
- Ensure that the local sepsis pathway facilitates the urgent surgical referral of patients who may require surgical source control of intra-abdominal sepsis.
- Ensure that local escalation processes are in place to support decision making and accountability to manage demand for theatre and conflicting surgical priorities.
- Ensure that local pathways and processes are in place to support timely, patient-centred decision making, and transfer for higher level care if required.
- Ensure systems and procedures facilitate capture of the date and time of the decision to operate in the patient's healthcare record.
- Monitor the demand and timeliness of surgery for patients requiring an emergency laparotomy to inform continuous quality improvement and facilitate planning and appropriate resource allocation. Identify and address sources of delay at all stages of the patient journey.

In hospitals that do not perform emergency laparotomy, ensure that local systems and policies support time-critical decision making and transfer as appropriate. (See [Box 2](#) for further considerations in relation to transfer.)

Indicator for local monitoring

Indicator 5a: Proportion of patients who had an emergency laparotomy within the timeframe specified by their assigned surgical urgency category.

METEOR link: meteor.aihw.gov.au/content/818257

More information about this indicator and the definitions needed to collect and calculate indicator data can be found online at the above METEOR link.

Quality statement 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.

Purpose

To ensure that high-risk patients receive care from clinicians whose expertise matches their needs.

What the quality statement means

For patients

If you have an increased risk of complications from your emergency laparotomy, you will have more experienced doctors directly involved in your operation. The experience and expertise of these senior doctors will help them to manage any complications that may occur during surgery and to make the best decisions about your treatment and recovery.

If you are in an area where these senior doctors may not be available, your healthcare team will consider transferring you to a hospital with the appropriate surgical team. If a transfer is not safe or practical because of your medical condition, your care will be guided by what is best for you, including your condition, how far you will need to travel, and what matters most to you.

For clinicians

For the high-risk emergency laparotomy patient, ensure that a consultant surgeon and consultant anaesthetist perform, or are present in theatre during, the patient's surgery and anaesthesia respectively. This includes when urgent surgery must occur overnight. (See [Box 3](#) for definitions of consultant surgeon and consultant anaesthetist. Note that in some rural settings a senior rural generalist anaesthetist may have an equivalent scope of practice.)

If it is considered appropriate in a particular case for a non-consultant to perform the surgery or provide anaesthesia under supervision, the supervising consultant should be physically present in theatre and free of other commitments.^{10,57}

The 'high-risk' patient is determined based on their overall risk, including their mortality risk (where a risk $\geq 5\%$ * is considered high risk), frailty and comorbidities, and clinical judgement.

* Estimated risk of death within 30 days of emergency laparotomy surgery.

When a consultant surgeon and/or consultant anaesthetist is not available locally, the following apply.

- As appropriate, arrange for the high-risk patient to be transferred to a facility with a suitably experienced surgical and anaesthetic team.
- In some cases, transfer or retrieval may not be possible or appropriate, or the urgency for definitive treatment or source control may require that the emergency laparotomy is performed locally with transfer afterwards for further intervention and critical care. These exceptions should be identified based on a risk-benefit analysis that considers factors such as the stability of the patient and urgency of treating their condition, the time involved in the earliest possible transfer or retrieval, and the patient's goals, values and preferences.
- Such decisions must involve discussion between the senior clinician responsible for the patient and the consultant of the surgical team likely to receive the patient after surgery.

See [Box 1](#) for discussion about implementing the Standard in regional, rural and remote settings, and [Box 2](#) for further information about transfers.

Box 3: Defining 'consultant' for the *Emergency Laparotomy Clinical Care Standard*

There is some variability across Australia in the use of the terms 'consultant surgeon' and 'consultant anaesthetist'. When they are used in this Standard, they should be considered, respectively, to mean the following.

- **Consultant surgeon:** A surgeon who has been granted specialist registration by Ahpra and the Medical Board of Australia; and has been appointed to a consultant position or equivalent senior position by a healthcare service, reflective of their experience and seniority; and is operating within their locally defined scope of practice.
- **Consultant anaesthetist:** An anaesthetist who has been granted specialist registration by Ahpra and the Medical Board of Australia; and has been appointed to a consultant position or equivalent senior position by a healthcare service, reflective of their experience and seniority. In some rural settings, this may be a rural generalist anaesthetist who has been appointed to a consultant, or equivalent senior position, by their healthcare service (or who has a similar scope of practice).

For healthcare services

The absence of consultants from operating theatres in emergency general surgery is associated with increased patient morbidity and mortality, and increased length of stay.⁵⁸

Implement policies, procedures and rostering arrangements to support the following.

- Ensure a consultant surgeon and consultant anaesthetist are present in theatre for high-risk patients undergoing emergency laparotomy. These consultants should be physically present in theatre and free of other commitments. (See [Box 3](#) above for definitions of consultant surgeon and consultant anaesthetist.) Consultant surgeons on the general surgery on-call roster should have adequate experience in gastrointestinal surgery.
- Enable monitoring and review of how frequently consultant doctors are present during surgery, to facilitate quality improvement as appropriate.

In services where a consultant surgeon or consultant anaesthetist is not available locally, ensure arrangements are in place that:

- support escalation, shared decision making and timely transfer or retrieval – subject to appropriate risk-benefit analysis – of the high-risk emergency laparotomy patient to a facility with a suitably experienced surgical team
- enable local clinicians including rural generalists to access virtual advice and support from senior clinicians at an appropriate tertiary centre to assist with decision making about the appropriate location for surgery and arrangements for transfer and clinical management.

See **Box 1** for discussion about implementing the Standard in regional, rural and remote setting, and **Box 2** for further information about transfers.

Indicators for local monitoring

Indicator 6a: Proportion of patients with a pre-operative mortality risk $\geq 5\%$ who had an emergency laparotomy, where a consultant surgeon was present in theatre during surgery.

METEOR link: meteor.aihw.gov.au/content/818259

Indicator 6b: Proportion of patients with a pre-operative mortality risk $\geq 5\%$ who had an emergency laparotomy, where a consultant anaesthetist was present in theatre during surgery.

METEOR link: meteor.aihw.gov.au/content/818261

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To ensure that high-risk patients who are having an emergency laparotomy are appropriately supported and monitored following their surgery.

What the quality statement means

For patients

If you are at very high risk of serious complications from your surgery, your doctors will arrange for you to have extra monitoring after your operation. If you have extra monitoring, it will often be in an intensive care unit (ICU) or high dependency unit (HDU). ICUs and HDUs have specialised nurses, doctors and medical equipment so you can be continuously monitored and quickly treated if any problems arise.

If there is no ICU or HDU available where you are, your doctors may suggest other ways of accessing extra monitoring. This may involve transferring you to another hospital. The options and choices will depend on your condition and what matters most to you.

For clinicians

Proactive admission of high-risk emergency general surgery patients to intensive care is associated with improved outcomes, including reduced mortality. Unplanned admission of patients to ICU from the ward following emergency gastrointestinal surgery is associated with very high mortality.^{8,9,61} Following an emergency laparotomy, many patients will benefit from the continuous monitoring and higher staffing ratios in critical care (ICU or HDU), to prevent or rapidly manage complications.^{8,61}

Consider the most appropriate postoperative care location for a patient having an emergency laparotomy, based on their mortality risk, frailty and comorbidities, and clinical judgement. (See [Quality statement 3](#) for more information about assessment of risk and frailty.)

Postoperative admission to critical care should be considered for all patients with a mortality risk $\geq 10\%$ – and as needed on a case-by-case basis for patients with a risk between 5 and 10%*. This involves the following.

- Discuss with a consultant intensivist, ideally before surgery, the need for direct postoperative admission to ICU or HDU. In services where there is no consultant intensivist, this discussion should be with the appropriate clinician responsible for critical care (for example, as determined by the consultant roster).
- Ensure discussions about postoperative critical care are also informed by the patient's goals of care. (See [Quality statement 4](#) for more information about shared decision making and goals of care.)
- Document discussions and decisions about the need for postoperative critical care in the patient's healthcare record. If the patient has a mortality risk $\geq 10\%$ and the decision is made not to admit to ICU or HDU postoperatively, document the reason in their record.

Once a decision has been made to operate, a patient should not be denied critical care on the basis of age or frailty alone.

For high-risk patients not admitted to critical care, ensure there is appropriate monitoring and prompt recognition and escalation of deterioration in accordance with local protocols and the *National Safety and Quality Health Service (NSQHS) Standard for Recognising and Responding to Acute Deterioration*.^{62,63} Where available, an enhanced care environment may be an appropriate location for continuous postoperative monitoring of some high-risk patients.

In services without an ICU or HDU, communicate as early as possible with consultant intensivists at the relevant tertiary hospital, other potential receiving hospital, or retrieval service if relevant, about the need for pre-operative or postoperative transfer of high-risk patients to an appropriate location. Ensure transfer decisions are informed by a risk-benefit assessment that considers the impact of the surgical procedure, the patient's ongoing therapeutic requirements and their goals and preferences. (See [Box 2](#) for further considerations regarding transfer.)

* Estimated risk of death within 30 days of emergency laparotomy surgery.

For healthcare services

Implement protocols, procedures and pathways that:

- enable planned postoperative admission to critical care for high-risk patients based on mortality risk, frailty and comorbidities, and clinical judgement
- facilitate discussion with a consultant intensivist, ideally pre-operatively, about the need for postoperative critical care – for all patients with a mortality risk $\geq 10\%$, and as needed on a case-by-case basis for patients with a mortality risk between 5 and 10%
- ensure documentation of the rationale for decisions not to admit high-risk patients to critical care, to facilitate review and interpretation of data for quality improvement
- facilitate appropriate monitoring of high-risk patients not admitted to critical care following emergency laparotomy to ensure prompt recognition and escalation in the event of deterioration in accordance with the *National Safety and Quality Health Service (NSQHS) Standard for Recognising and Responding to Acute Deterioration*.

In services without critical care on-site, ensure that protocols, procedures and pathways facilitate timely shared decision making, and pre-operative or postoperative transfer of the high-risk emergency laparotomy patient for critical care when this is in the best interests of the patient, and aligned with their goals of care. (See [Box 2](#) for further considerations regarding transfer.)

Indicators for local monitoring

Indicator 7a: Proportion of patients with a pre-operative mortality risk $\geq 10\%$ who had an emergency laparotomy, with documentation that postoperative critical care was discussed with a consultant intensivist before surgery.

METEOR link: meteor.aihw.gov.au/content/818263

Indicator 7b: Proportion of patients who had an emergency laparotomy, who had an unplanned admission to critical care from the ward.

METEOR link: meteor.aihw.gov.au/content/818265

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To ensure that older patients who undergo an emergency laparotomy receive appropriate, timely medical co-management from suitably experienced physicians.

What the quality statement means

For patients

If you are an older adult, you will benefit from having another doctor on your healthcare team who has expertise in caring for older people having surgery. This may be a geriatrician or a general physician.

Ideally, you will see this doctor in the first few days that you are in hospital. They can work with you and your family and support people, your surgeon and your other healthcare providers to address your overall health needs and support your recovery. For example, they can help with:

- managing other medical conditions that may affect your recovery
- preventing or managing complications (for example, delirium, which is a change in a person's thinking or behaviour which often appears as new or increasing confusion)
- understanding any frailty-related challenges you may have
- working with other healthcare providers to support nutrition, mobility and other aspects of your recovery
- managing changes to your medicines
- helping you and your support people to make important decisions about your care
- coordinating care with the rest of your healthcare team.

For clinicians

Comprehensive Geriatric Assessment (CGA) is a multi-dimensional, interdisciplinary process used to assess an older person's medical, psychosocial and functional capabilities and develop a comprehensive management plan.⁶⁴ It includes multidisciplinary management to support early mobilisation, assess and treat pain, prevent complications and facilitate recovery, with appropriately skilled nursing, pharmacy, physiotherapy, dietetic and other allied health input.^{9,65} CGA is associated with improved outcomes for older emergency general surgery patients, including reduced mortality and length of stay.^{9,26,32,64}

In line with local protocols, arrange for the patient aged 65 years or older who is undergoing emergency laparotomy to be assessed by an appropriate physician as early as possible post-operatively – and pre-operatively where feasible and of benefit to the patient – with assessment occurring no later than 72 hours following presentation to hospital. Timely assessment by an appropriate physician is also required for a patient undergoing emergency laparotomy following deterioration on the ward, or on step-down from critical care.

In most settings, the 'appropriate physician' will be a geriatrician or general physician, and will have expertise in the perioperative care of older adults. In regional, rural and remote settings, it may be a suitably skilled general practitioner or rural generalist.

Aboriginal and Torres Strait Islander people may experience chronic health conditions that can impact their recovery earlier in life. Medical input to their care should also be considered on an individual basis from 45 years. Similarly, other younger patients with complex care needs will benefit from medical assessment and co-management.

The involvement of an appropriately skilled physician in jointly managing the older patient undergoing emergency laparotomy can support:

- assessment and management of multimorbidity, polypharmacy and age-related physiological decline and geriatric syndromes (such as frailty, malnutrition and cognitive impairment) throughout the perioperative pathway^{48,64}
- assessment and management of postoperative complications, hospital-acquired deconditioning, postoperative cognitive disorders including delirium, and medications
- shared decision making and values-based discussions about goals of care and limitations on medical treatment including in the postoperative period (see [Quality statement 4](#))
- coordinated multidisciplinary management
- early identification of the most appropriate service to deliver rehabilitation, if indicated
- goal setting and proactive discharge planning (see [Quality statement 9](#)).⁶

For healthcare services

Local systems, pathways and protocols – tailored to service size and complexity, and the needs of the local patient population – should ensure:

- appropriate physicians are involved in the assessment and collaborative management of older patients undergoing emergency laparotomy – including all adult patients aged 65 years and older, and Aboriginal and Torres Strait Islander patients aged 45 years older who may be at increased risk and should be considered on an individual basis
- assessment occurs as early as practicable and no later than 72 hours following presentation to hospital (or as early as appropriate following step-down from postoperative critical care, or for patients having an emergency laparotomy following deterioration on the ward).

'Appropriate physicians' include geriatricians, or general physicians, with expertise in the perioperative care of older adults. In regional, rural and remote services, this may include suitably skilled general practitioners or rural generalists, or in some cases appropriate physicians may be consulted remotely.

See [Box 1](#) for discussion about implementing the Clinical Care Standard in regional, rural and remote areas.

To support the collaborative management of older emergency laparotomy patients, local systems, pathways and protocols should also enable:

- the proactive engagement of suitably skilled nursing, pharmacy and allied health professionals such as dietitians and physiotherapists as needed, including in the postoperative phase
- early discharge planning with multidisciplinary input as needed including from the patient's usual clinicians, and access to appropriate subacute and restorative care services
- education and training for clinicians, appropriate to their role, in the care of older surgical patients.

Examples of arrangements that support collaborative management of older patients include perioperative medicine teams and Perioperative Care of Older Persons undergoing Surgery services.^{5,26,66}

Consider, and implement as appropriate, the systems and processes needed to support collaborative management of younger, complex patients who also need comprehensive assessment and co-management by an appropriate physician.

Related resources

- [A framework for perioperative care in Australia and New Zealand](#) (ANZCA, 2021)

Indicators for local monitoring

Indicator 8a: Evidence of local arrangements that ensure older emergency laparotomy patients are proactively assessed and collaboratively managed by an appropriate physician skilled in the perioperative care of older adults.

METEOR link: meteor.aihw.gov.au/content/818267

The local arrangements should be tailored to service size and complexity and the needs of the local population and specify the processes to:

- ensure older people who are undergoing emergency laparotomy are assessed by an appropriate physician within 72 hours of presentation to hospital
- support involvement of appropriate physicians in the collaborative management of older emergency laparotomy patients
- support implementation and monitoring of the local arrangements.

Indicator 8b: Proportion of patients aged 65 years or older who had an emergency laparotomy, who were assessed within 72 hours of hospital presentation by an appropriate physician.

METEOR link: meteor.aihw.gov.au/content/818271

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Quality statement 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.

Purpose

To support ongoing individualised care and recovery after discharge for patients who have had an emergency laparotomy.

What the quality statement means

For patients

Before you leave hospital, your healthcare team will talk with you and your family and support people about a plan for your recovery and your ongoing care needs. Clinicians like physiotherapists, nurses or other doctors may also help to develop the plan.

Your plan will outline who to contact if you experience complications or you are concerned about your recovery. It will also address things like:

- your recovery goals
- medicines you need to take, including changes to your existing medicines
- lifestyle changes you may need to make, including changes to your diet
- managing your other health conditions and preventing complications
- what you can do if you have any mental health concerns such as anxiety
- rehabilitation services and equipment you require
- follow-up appointments you will need and other useful contacts such as community supports.

You will get a copy of your plan before you leave hospital. A copy will also be sent to your general practitioner (GP) or other primary healthcare provider and any other clinicians who will be helping you with your recovery.

For clinicians

Before the patient leaves hospital following an emergency laparotomy, the following are important:

- Develop an individualised care plan with the patient and their family and/or support people; present the plan in a way that the patient and their support people can understand. (See key considerations for inclusion in the care plan in [Box 4](#) below.)
- Explain what the patient can expect during the recovery period, including follow-up appointments they will need
- Provide a copy of the care plan to the patient and their family and/or support people.

For older patients, patients with frailty and other patients with complex care needs, ensure early multidisciplinary input into recovery planning and coordination of discharge. This may include, but is not limited to, input from geriatricians or other appropriate physicians, pharmacists, nurses, physiotherapists, occupational therapists, dietitians and/or social workers.

Consider the needs of patients who were transferred from their local area for surgery and/or postoperative management. Involve them and their support people in decisions about the appropriate location for rehabilitation and other follow-up care. Arrange for follow-up care to be provided as close to home as possible. Consider the suitability of alternative service delivery models such as telehealth where these may help meet the patient's needs and preferences.

On discharge, provide the plan directly to the patient's general practice and other regular clinicians and care providers. General practitioners – and other primary healthcare practitioners – play a critical role in monitoring complications, supporting medication changes, managing multimorbidity and psychosocial recovery. Enable uploading of the plan by default to My Health Record, which allows other clinicians to access details about the patient's care.

For patients transitioning to another hospital or setting for rehabilitation or follow-up care, provide the plan as part of their documented handover.

Box 4: Key considerations for inclusion in an individualised care plan on discharge⁶⁷

- Contact details of the treating team and other information about what to do if the patient becomes acutely unwell or has questions about their recovery
- Goals for recovery
- Information about medicines (including new or changed medicines) and ongoing pain management strategies
- Guidance on nutrition, wound care and mobilisation
- Guidance on managing comorbidities during recovery, and on managing persistent delirium if present; strategies to prevent complications such as those related to infection or venous thromboembolism^{35,68,69}
- Rehabilitation equipment needed and contact details for rehabilitation services including referral as required
- Advice on responding to mental health concerns such as anxiety and loss of confidence
- Advice about accessing restorative care and/or multidisciplinary community care if needed, for example, through a hospital in the home program or a GP chronic condition management plan
- Follow-up appointments required, including with the patient's general practitioner and rehabilitation services if relevant, and contact details for appropriate community supports
- For patients who have had sepsis, information on post-sepsis syndrome and available supports (see [Sepsis Clinical Care Standard](#), Quality statement 7).³⁵

For healthcare services

Ensure that systems, protocols and procedures are in place to:

- facilitate multidisciplinary input into discharge planning as needed, particularly for older patients, patients with frailty and other patients with complex care needs
- support clinicians to develop an individualised care plan with patients before discharge, addressing the key considerations outlined in [Box 4](#) as appropriate
- refer patients to the relevant services and supports as required
- consider the specific needs of patients who were transferred out of their local area for surgery and/or postoperative management, and who are returning home on discharge, or following a period of rehabilitation.

Ensure that clinical information systems support clinicians in providing the discharge summary and care plan to the patient, and communicating the content to their general practitioner, and other care providers (such as residential aged care facilities, or community aged care providers) at the time of discharge. Enable uploading of information by default to the patient's My Health Record to support appropriate sharing of information on the care provided in hospital and the patient's ongoing care needs.



Cultural safety and equity

Consider the patient's cultural needs, preferences and goals and their impact on the individualised care plan. It is important for the care plan to reflect the lived realities of the person and consider what supports are available within the family and community. Consider the culturally appropriate services, supports and contacts available for patients leaving hospital after an emergency laparotomy.

Ensure that information about recovery and the care plan is provided in a way that the patient and their support people understand and is culturally safe.

Consider the structured support that may be needed, including travel arrangements, for people to safely return to their home when they have had surgery away from their community or Country.

Where accessing follow-up care may be difficult due to distance or other access issues, offer to contact the patient's nominated primary healthcare provider to advise that they are being discharged and discuss suitable support arrangements. For Aboriginal and Torres Strait Islander patients and their support people, Aboriginal Community Controlled Health Organisations (ACCHOs) and Aboriginal Medical Services can play an important role in providing access to relevant support after discharge, especially in rural and remote areas. Involve an Aboriginal and Torres Strait Islander Health Worker, Health Practitioner or Liaison Officer when this is the patient's preference.

Indicators for local monitoring

Indicator 9a: Evidence of local arrangements for the development of a written individualised care plan for emergency laparotomy patients before discharge from hospital.

METEOR link: meteor.aihw.gov.au/content/818273

The local arrangements should specify the:

- process to involve the patient and their family or support people in development of the care plan
- process to ensure input from multidisciplinary team members in the development of the care plan, when needed
- information that should be documented in the patient's care plan
- process to ensure that the patient's care plan is provided to the patient and directly to their nominated general practitioner or other primary healthcare provider at the time of discharge from hospital, and to their other regular clinicians and care providers
- process for addressing the specific needs of patients who were transferred out of their local area for surgery or rehabilitation
- process to support implementation and monitoring of the local arrangements.

Indicator 9b: Proportion of patients who had an emergency laparotomy, whose discharge summary was sent to their nominated primary healthcare provider at the time of discharge from hospital.

METEOR link: meteor.aihw.gov.au/content/818275

More information about the indicators and the definitions needed to collect and calculate them can be found online in the above METEOR links.

Glossary

Term	Definition
advance care directive	A voluntary, person-led instructional document that records a person's decisions, preferences, or personal values about medical treatments in case they lose decision making capacity in the future.
advance care planning	A process of planning for future health and personal care whereby a person's values, beliefs and preferences are made known to guide decision making at a future time when that person cannot make or communicate their decisions.
clinicians	Healthcare providers who deliver direct clinical care to patients. Clinicians include surgeons, anaesthetists, intensivists, emergency physicians, geriatricians, general physicians, rural generalists, general practitioners, nurses, pharmacists, Aboriginal and/or Torres Strait Islander Health Workers, Aboriginal and/or Torres Strait Islander Health Practitioners and allied health professionals.
cognitive impairment	Deficits in one or more of the areas of memory, communication, attention, thinking, problem solving and judgement. Cognitive impairment can be temporary or permanent. It can affect a person's understanding, their ability to carry out tasks or follow instructions, their recognition of people or objects, how they relate to others and how they interpret the environment. Dementia and delirium are common forms of cognitive impairment seen in older people in all healthcare settings. ⁷¹
consultant anaesthetist	An anaesthetist who has been granted specialist registration by Ahpra and the Medical Board of Australia; and has been appointed to a consultant position or equivalent senior position by a healthcare service, reflective of their experience and seniority. In some rural settings, this may be a rural generalist anaesthetist who has been appointed to a consultant, or equivalent senior position, by their healthcare service (or who has an equivalent scope of practice).
consultant intensivist	An intensivist who has been granted specialist registration by Ahpra and the Medical Board of Australia; and has been appointed to a consultant position or equivalent senior position by a healthcare service, reflective of their experience and seniority. For this Clinical Care Standard, in some settings this will be a senior clinician of a different specialty identified as being responsible for critical care (for example, on the consultant roster).

Term	Definition
consultant surgeon	A surgeon who has been granted specialist registration by Ahpra and the Medical Board of Australia; and has been appointed to a consultant position or equivalent senior position by a healthcare service, reflective of their experience and seniority; and is operating within their locally defined scope of practice.
critical care	An intensive care unit (ICU) or high dependency unit (HDU) that provides intensive nursing and medical care to critically ill patients under the supervision of an intensivist. Critical care units are characterised by continuous supervision and the use of advanced monitoring and resuscitative equipment. <i>See also intensive care unit and high dependency unit.</i>
cultural safety	Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. In health care, culturally safe practice is the ongoing critical reflection of knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive health care free of racism. Essential features of cultural safety are individuals and organisations: <ul style="list-style-type: none"> • Acknowledging colonisation and systemic racism, and social, cultural, behavioural and economic factors which impact individual and community health • Acknowledging and addressing individual racism, and their own biases, assumptions, stereotypes and prejudices, and providing care that is holistic, and free of bias and racism • Recognising the importance of self-determined decision making, partnership and collaboration in health care which is driven by the individual, family and community • Fostering a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.
delirium	A disturbance of consciousness, attention, cognition and perception that develops over a short period of time (usually hours or days) and tends to fluctuate during the course of the day. Recovery can be complete if the underlying cause (for example, physical illness, drug toxicity) is promptly corrected or self-limited. ⁶⁸ Full recovery may not always occur; delirium can unmask or accelerate underlying dementia or cognitive decline.
emergency laparotomy	Laparotomy is a major operation in which the abdomen is cut open to examine or treat a problem inside the gastrointestinal tract. It encompasses surgical exploration of the acute abdomen for a number of underlying pathologies. In an emergency context, common causes are intestinal obstruction, perforation and exploratory laparotomy with or without wound debridement or abscess drainage. ⁷ For the Clinical Care Standard, and the ERAS Society guidelines which underpin the Standard, the term 'emergency' is applied to all patients with a non-elective, potentially life-threatening intra-abdominal condition requiring surgery, excluding trauma laparotomies, vascular conditions, appendectomy and cholecystectomy. <i>See also discussion under Scope.</i>
frailty	A state in which an individual is more vulnerable to increased dependency and/or mortality when exposed to a physiological or psychological stressor. ⁷²

Term	Definition
gastrointestinal tract	The organs that food and liquids travel through when they are swallowed, digested, absorbed, and leave the body as faeces.
geriatric syndromes	Clinical conditions common in older people, with substantial implications for functioning and quality of life – such as delirium and cognitive impairment, polypharmacy, falls and immobility. ^{64,73}
goals of care	Clinical and other goals for a patient's episode of care that are determined in the context of a shared decision making process. ¹
goals of care forms	Local health service or hospital forms that document a patient's goals of care during a hospital admission and escalation or non-escalation (limitations) of medical treatment. These clinical directive forms may be known by alternative terms – such as a statement of choices form. They are distinct from advance care directives, which are patient-driven legal documents. ⁵⁴
healthcare services	Organisations responsible for leading and governing one or more service units providing health care to patients; their responsibilities include clinical governance, administration and financial management. Health care is delivered in a wide range of settings. Services may vary in size and organisational structure from single healthcare providers to complex organisations.
high dependency unit (HDU)	A specially staffed and equipped area of a hospital that provides a level of care intermediate between intensive care and general ward care. Hospitals with a designated ICU may have HDU beds located within them.
intensive care unit (ICU)	A designated area of a hospital which is staffed and equipped to provide observation, care and treatment to patients with actual or potential life-threatening illnesses, injuries or complications, from which recovery is possible. The ICU provides special expertise and facilities for the support of vital functions and utilises the skills of medical, nursing and other staff trained and experienced in the management of these problems. ⁷⁴
lactate	A non-specific marker of illness severity in acutely ill patients. Lactate is usually present in low levels in the blood, and elevated levels can indicate either a protective or maladaptive response to shock. ⁷⁵
limitations on medical treatment	Medical decisions that may be made which limit the treatments that are, or could be, provided when they will not benefit the person. A decision to not attempt cardiopulmonary resuscitation if a person suffers a cardiopulmonary arrest is one example of a limitation on medical treatment. Decisions to limit medical treatment may avoid prolongation of dying but will not cause a person's death. Similar terms in common use include withdrawal or withholding of medical treatment. ⁵¹

Term	Definition
Metadata Online Registry (METEOR)	<p>METEOR is Australia's web-based repository for national metadata standards for health, housing and community services statistics and information. Hosted by the Australian Institute of Health and Welfare (AIHW), METEOR provides users with a suite of features and tools, including online access to a wide range of nationally endorsed data and indicator definitions.</p> <p>The AIHW METEOR website contains more information about this indicator set and the definitions needed to collect and calculate indicator data. Links are provided with the relevant quality statements.</p>
non-beneficial treatment	Interventions that will not be effective in treating a person's medical condition or improving their quality of life. Non-beneficial treatment may include interventions such as diagnostic tests, medicines, artificial hydration and nutrition, intensive care, and medical or surgical procedures. Non-beneficial treatment is sometimes referred to as futile treatment, but this is not a preferred term. ⁶⁸
older adult	Where care is described in this Clinical Care Standard for older adults or older patients, 'older adults' refers to all people aged 65 years and above. It applies to Aboriginal and Torres Strait Islander people aged 45 years and above on an individual basis, recognising that Aboriginal and Torres Strait Islander people may experience chronic health conditions that can impact their recovery earlier in life.
palliative care	An approach to treatment that improves the quality of life of people and their families facing life-limiting illness by preventing and relieving suffering. It involves early identification, assessment and treatment of pain and other problems (physical, psychosocial and spiritual). ⁵¹
patient	<p>The person receiving care. When the word 'patient' is used in this Standard, it may include the person's carer, family member, support person, or substitute decision maker.</p> <p>Only the patient or their substitute decision maker, such as a legal guardian, can give consent for care. However, carers, families and support people who are not substitute decision makers may also support the patient in their decision making and actively participate in their care. These people should be given information and included in discussions when the patient wishes this to occur.</p>
perioperative care	The multidisciplinary, integrated, personalised care of patients from the moment surgery is contemplated through to an optimal outcome. ⁵
perioperative medicine	The science and practice of working with patients from the moment surgery is contemplated, to optimise their health and wellbeing, minimise the risk of perioperative complications, and facilitate optimal recovery, underpinned by shared decision making. ⁵
person-centred care	Health care that respects the patient, their family and carers, and responds to the person's preferences, needs and values. Person-centred care is equitable, culturally safe and free from racism and all other forms of discrimination.
rural generalist anaesthetist	A rural generalist or rural general practitioner who has completed accredited advanced skills training in anaesthetics. ⁷⁵

Term	Definition
sepsis	A time-critical medical emergency that arises when the body's response to an infection damages its own tissues and organs, leading to failure of multiple organs and death if not recognised and treated ptly. ¹ Sepsis can occur in response to various types of infections, including bacterial, viral or fungal infections acquired in community or healthcare settings.
shared decision making	A discussion and collaboration between a person and their healthcare worker that brings together the person's values, goals and preferences with the best available evidence about benefits, risks and uncertainties of treatment, in order to reach the most appropriate healthcare decisions for that person. ¹
source control	The identification and removal of an infection source to halt the ongoing microbial contamination of a normally sterile organ, tissue or body cavity. ⁶⁰
substitute decision maker	A person appointed or identified by law to make health, medical, residential and other personal (but not financial or legal) decisions on behalf of a patient whose decision making capacity is impaired. A substitute decision maker may be appointed by the patient, appointed for (on behalf of) the patient, or identified as the default decision maker by legislation, which varies by state and territory.
substitute decision making	Where an individual has the legal right to make health care, personal and lifestyle decisions on behalf of a person with impaired decision making capacity, by seeking to replicate decisions that the person would have made, if able.

References

1. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Health Service Standards (second edition). Sydney: ACSQHC; 2017.
2. Australian Commission on Safety and Quality in Health Care. National Safety and Quality Primary and Community Healthcare Standards. Sydney: ACSQHC; 2021.
3. Australian Commission on Safety and Quality in Health Care. Fact sheet 11: Applicability of Clinical Care Standards. Sydney: ACSQHC; 2023.
4. Australian Commission on Safety and Quality in Health Care. Joint Statement: Working Together to Achieve Sustainable High-quality Health Care in a Changing Climate. Sydney: ACSQHC; 2024.
5. Australia and New Zealand College of Anaesthetists. A framework for perioperative care in Australia and New Zealand. Melbourne: ANZCA; 2023.
6. Centre for Perioperative Care. Guideline for Perioperative Care for People Living with Frailty Undergoing Elective and Emergency Surgery. London: CPOC; 2021.
7. Peden CJ, Aggarwal G, Aitken RJ, et al. Guidelines for Perioperative Care for Emergency Laparotomy Enhanced Recovery After Surgery (ERAS®) Society Recommendations: Part 1 – Pre-operative: Diagnosis, Rapid Assessment and Optimization. *World J Surg.* 2021;45(5):1272–90.
8. Scott MJ, Aggarwal G, Aitken RJ, et al. Consensus Guidelines for Perioperative Care for Emergency Laparotomy Enhanced Recovery After Surgery (ERAS®) Society Recommendations Part 2 – Emergency Laparotomy: Intra- and Postoperative Care. *World J Surg.* 2023;47(8):1850–80.
9. Peden CJ, Aggarwal G, Aitken RJ, et al. Enhanced Recovery After Surgery (ERAS®) Society Consensus Guidelines for Emergency Laparotomy Part 3 – Organizational Aspects and General Considerations for Management of the Emergency Laparotomy Patient. *World J Surg.* 2023;47(8):1881–98.
10. Royal College of Surgeons of England. The high-risk general surgical patient: raising the standard. London: RCSE; 2018.
11. NELA Project Team. Ninth patient report of the National Emergency Laparotomy Audit (NELA). London: Royal College of Anaesthetists; 2024.
12. Royal Australasian College of Surgeons. ANZ Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI) [Internet]. Melbourne: RACS; 2025. www.surgeons.org/research-audit/morbidity-audits/morbidity-audits-managed-by-racs/anz-emergency-laparotomy-audit-quality-improvement (accessed Sep 2025).
13. Australian Commission on Safety and Quality in Health Care. NSQHS Standards User Guide for Aboriginal and Torres Strait Islander Health. Sydney: ACSQHC; 2017.
14. Australian Commission on Safety and Quality in Health Care. User Guide for Reviewing Clinical Variation. Sydney: ACSQHC; 2023.

15. Australian Health Ministers' Advisory Council's National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural respect framework 2016–2026 for Aboriginal and Torres Strait Islander health. Canberra: AHMAC; 2016.
16. Australian Health Practitioner Regulation Agency. Aboriginal and Torres Strait Islander Health Strategy [Internet]. Ahpra; 2023. www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx (accessed Dec 2025).
17. Lin I, Green C, Bessarab D. 'Yarn with me': applying clinical yarning to improve clinician-patient communication in Aboriginal health care. *Aust J Prim Health*. 2016;22(5):377–82.
18. Centre for Aboriginal Health. Communicating positively: A guide to appropriate Aboriginal terminology. Sydney: NSW Health; 2019.
19. Northern Territory Government. Plain English health dictionary. Darwin: Aboriginal Interpreter Service; 2023.
20. Burmas M, Aitken RJ, Broughton KJ. Outcomes following emergency laparotomy in Australian public hospitals. *ANZ J Surg*. 2018;88(10):998–1002.
21. Australian and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI). Second ANZELA-QI program summary report 1 January 2020 to 31 December 2021. Melbourne: Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists; 2022.
22. Fagan G, Barazanchi A, Coulter G, et al. New Zealand and Australia emergency laparotomy mortality rates compare favourably to international outcomes: a systematic review. *ANZ J Surg*. 2021;91(12):2583–91.
23. Peacock O, Yanni F, Kuryba A, et al. Failure to rescue patients after emergency laparotomy for large bowel perforation: analysis of the National Emergency Laparotomy Audit (NELA). *BJS Open*. 2021;5(1).
24. Saunders DI, Sinclair RCF, Griffiths B, et al. Emergency Laparotomy Follow-Up Study (ELFUS): prospective feasibility investigation into postoperative complications and quality of life using patient-reported outcome measures up to a year after emergency laparotomy. *Perioper Med (Lond)*. 2021;10(1):22.
25. Khanderia E, Aggarwal R, Bouras G, et al. Quality of life after emergency laparotomy: a systematic review. *BMC Surg*. 2024;24(1):73.
26. Aitken RM, Partridge JSL, Oliver CM, et al. Older patients undergoing emergency laparotomy: observations from the National Emergency Laparotomy Audit (NELA) years 1–4. *Age Ageing*. 2020;49(4):656–63.
27. Parmar KL, Law J, Carter B, et al. Frailty in Older Patients Undergoing Emergency Laparotomy: Results From the UK Observational Emergency Laparotomy and Frailty (ELF) Study. *Ann Surg*. 2021;273(4):709–18.
28. O'Brien P, Bunzli S, Lin I, et al. Addressing surgical inequity for Aboriginal and Torres Strait Islander people in Australia's universal health care system: a call to action. *ANZ J Surg*. 2021;91(3):238–44.
29. Australian Institute of Health Welfare. Health and wellbeing of First Nations people [Internet]. Canberra: AIHW, 2024. www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing (accessed Dec 2025).
30. James Aitken R, Griffiths B, Van Acker J, et al. Two-year outcomes from the Australian and New Zealand Emergency Laparotomy Audit-Quality Improvement pilot study. *ANZ J Surg*. 2021;91(12):2575–82.
31. Australia and New Zealand Emergency Laparotomy Audit – Quality Improvement (ANZELA-QI). Third ANZELA-QI program summary report, 1 January 2022 to 31 December 2024. Melbourne: Royal Australasian College of Surgeons and the Australian and New Zealand College of Anaesthetists; 2025.
32. Oliver CM, Bassett MG, Poulton TE, et al. Organisational factors and mortality after an emergency laparotomy: multilevel analysis of 39 903 National Emergency Laparotomy Audit patients. *Br J Anaesth*. 2018;121(6):1346–56.

33. Royal College of Emergency Medicine. RCEM Advisory Statement Regarding the Management of Adults Presenting to the Emergency Department Who May Require an Emergency Laparotomy. London: RCEM; 2024.
34. Australasian College for Emergency Medicine. Guidelines on the implementation of the Australasian Triage Scale in emergency departments. Melbourne: ACEM; 2022.
35. Australian Commission on Safety and Quality in Health Care. Sepsis Clinical Care Standard. Sydney: ACSQHC; 2022.
36. Jobin SP, Maitra S, Baidya DK, et al. Role of serial lactate measurement to predict 28-day mortality in patients undergoing emergency laparotomy for perforation peritonitis: prospective observational study. *J Intensive Care*. 2019;7:58.
37. Waugh EB, Hefler M, Pascoe S, et al. What do Aboriginal people in the Northern Territory value during the operation journey? A qualitative study. *Med J Aust*. 2025;223(1):30–7.
38. Limmer AM, Edey MB. Interhospital transfer delays emergency abdominal surgery and prolongs stay. *ANZ J Surg*. 2017;87(11):867–72.
39. Australian and New Zealand College of Anaesthetists. Joint Guideline for the Transport of Critically Ill Patients. Melbourne: ACEM, ANZCA, CICM; 2025.
40. Scheirey CD, Fowler KJ, Therrien JA, et al. ACR Appropriateness Criteria® Acute Nonlocalized Abdominal Pain. *J Am Coll Radiol*. 2018;15(11):S217–31.
41. Royal College of Emergency Medicine and Royal College of Radiologists. Joint Advisory Statement between Royal College of Radiologists & Royal College Emergency Medicine regarding Emergency Computed Tomography scans and the use of Intravenous Iodinated Contrast Agents [Internet]. London: RCR; 2023. www.rcr.ac.uk/news-policy/latest-updates/joint-advisory-statement-between-the-royal-college-of-radiologists-royal-college-emergency-medicine-regarding-emergency-computed-tomography-scans-and-the-use-of-intravenous-iodinated-contrast-agents (accessed Dec 2025).
42. The Royal Australian and New Zealand College of Radiologists. Iodinated Contrast Media Guideline. Sydney: RANZCR; 2018.
43. The Royal Australian and New Zealand College of Radiologists. Position statement: Clinical radiology critical results and adverse outcomes notification, Version 1.1. Sydney: RANZCR; 2024.
44. The Royal Australian and New Zealand College of Radiologists. Standards of Practice for Clinical Radiology, Version 11.2. Sydney: RANZCR; 2020.
45. Tran ET, Ho KM. Utility of the National Emergency Laparotomy Audit prognostic model in predicting outcomes in an Australian health system. *Anaesth Intensive Care*. 2023;51(1):51–58.
46. Hunter Emergency Laparotomy Collaborator Group. High-Risk Emergency Laparotomy in Australia: Comparing NELA, P-POSSUM, and ACS-NSQIP Calculators. *J Surg Res*. 2020;246:300–4.
47. Barazanchi A, Bhat S, Palmer-Neels K, et al. Evaluating and improving current risk prediction tools in emergency laparotomy. *J Trauma Acute Care Surg*. 2020;89(2):382–7.
48. British Geriatrics Society. BGS Position Statement: Older Patients Undergoing Emergency Laparotomy. London: BGS; 2020.
49. Chan R, Ueno R, Afroz A, et al. Association between frailty and clinical outcomes in surgical patients admitted to intensive care units: a systematic review and meta-analysis. *Br J Anaesth*. 2022;128(2):258–71.
50. Tiegies Z, Maclullich AMJ, Anand A, et al. Diagnostic accuracy of the 4AT for delirium detection in older adults: systematic review and meta-analysis. *Age Ageing*. 2021;50(3):733–43.
51. Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for safe and high-quality end-of-life care. Sydney: ACSQHC; 2023.
52. Kruser JM, Nabozny MJ, Steffens NM, et al. ‘Best Case/Worst Case’: Qualitative Evaluation of a Novel Communication Tool for Difficult in-the-Moment Surgical Decisions. *J Am Geriatr Soc*. 2015;63(9):1805–11.

53. Anstey MH, Senthuran S. The what-if approach to perioperative planning. *Anaesth Intensive Care*. 2023;51(3):168–9.
54. Australian and New Zealand College of Anaesthetists. PG67(G) Guideline for the care of patients at the end-of-life who are considered for surgery or interventional procedures 2022. Melbourne: ANZCA; 2022.
55. Barnett G, Swart M. Shared decision making for high-risk surgery. *BJA Educ*. 2021;21(8):300–6.
56. Bonus C, Northall T, Hatcher D, et al. Experiences of perioperative care among ethnically diverse older adult patients: An integrative review. *Collegian*. 2022;29(6):911–23.
57. Royal Australasian College of Surgeons. RACS Position Paper: Emergency Surgery. Melbourne: RACS; 2015.
58. NSW Agency for Clinical Innovation. NSW emergency surgery guidelines and principles for improvement. Sydney: ACI; 2021.
59. Boyd-Carson H, Doleman B, Cromwell D, et al. Delay in Source Control in Perforated Peptic Ulcer Leads to 6% Increased Risk of Death Per Hour: A Nationwide Cohort Study. *World J Surg*. 2020;44(3):869–75.
60. De Waele JJ. Importance of timely and adequate source control in sepsis and septic shock. *J Intensive Med*. 2024;4(3):281–6.
61. Vester-Andersen M, Lundstrøm LH, Møller MH, et al. Mortality and postoperative care pathways after emergency gastrointestinal surgery in 2904 patients: a population-based cohort study. *Br J Anaesth*. 2014;112(5):860–70.
62. Australian Commission on Safety and Quality in Health Care. National consensus statement: Essential elements for recognising and responding to acute physiological deterioration. Sydney: ACSQHC; 2021.
63. Ludbrook G, Lloyd C, Story D, et al. The effect of advanced recovery room care on post-operative outcomes in moderate-risk surgical patients: a multicentre feasibility study. *Anaesthesia*. 2021;76(4):480–8.
64. Australian and New Zealand Society for Geriatric Medicine. ANZSGM Position Statement Perioperative Care of Older People. Sydney: ANZSGM; 2022.
65. Boden I, Sullivan K, Hackett C, et al. Intensive physical therapy after emergency laparotomy: Pilot phase of the Incidence of Complications following Emergency Abdominal surgery Get Exercising randomized controlled trial. *J Trauma Acute Care Surg*. 2022;92(6):1020–30.
66. Partridge J, Sbai M, Dhesi J. Proactive care of older people undergoing surgery. *Aging Clin Exp Res*. 2018;30(3):253–7.
67. Silva L, Crole Rees C, Watts T, et al. SP4.2.2 Recovery after Emergency Laparotomy – what do patients want? *Br J Surg*. 2022;109(Supplement_5).
68. Australian Commission on Safety and Quality in Health Care. Delirium Clinical Care Standard. Sydney: ACSQHC; 2021.
69. Australian Commission on Safety and Quality in Health Care. Venous Thromboembolism Prevention Clinical Care Standard. Sydney: ACSQHC; 2020.
70. Spurling LJ, Moonesinghe SR, Oliver CM. Validation of the days alive and out of hospital outcome measure after emergency laparotomy: a retrospective cohort study. *Br J Anaesth*. 2022;128(3):449–56.
71. Department of Health and Aged Care. Glossary for the guiding principles and user guide. Canberra: Australian Government; 2022.
72. Church S, Rogers E, Rockwood K, et al. A scoping review of the Clinical Frailty Scale. *BMC Geriatr*. 2020;20(1):393.
73. Inouye SK, Studenski S, Tinetti ME, et al. Geriatric syndromes: clinical, research, and policy implications of a core geriatric concept. *J Am Geriatr Soc*. 2007;55(5):780–91.
74. Australian Institute of Health and Welfare. Intensive care unit [Internet]. Canberra: AIHW; 2018. [meteor.aihw.gov.au/content/327234](https://www.aihw.gov.au/content/327234) (accessed Sep 2025).

75. Australian and New Zealand College of Anaesthetists. Rural Generalist Anaesthesia training program [Internet]. ANZCA; www.anzca.edu.au/education-and-training/anaesthesia-training-and-pathways/rural-generalist-anaesthesia-training-program (accessed Apr 2026).
76. Australian Commission on Safety and Quality in Health Care. National Sepsis Program [Internet]. Sydney: ACSQHC; 2025. www.safetyandquality.gov.au/our-work/national-sepsis-program (accessed Sep 2025).

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The above artwork used throughout the document was designed by Ms Lani Balzan, a Wiradjuri artist from the south coast of New South Wales. The central symbol is the logo for the Clinical Care Standards program, which began at the Commission in 2013. The outer four circles of the artwork represent the four priority areas of patient safety; partnering with patients, consumers and communities; quality, cost and value; and supporting health professionals to provide care that is informed, supported and organised to deliver safe and high-quality health care. The outer dots represent growth, healing, change and improvement.



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