Australian Commission on **Safety and Quality** in Health Care

Clinical Care Standards

Emergency Laparotomy Clinical Care Standard

Information for clinicians

About the *Emergency Laparotomy Clinical Care Standard*

The *Emergency Laparotomy Clinical Care Standard* aims to drive high-quality and timely assessment, diagnosis and management of patients undergoing emergency laparotomy, and to optimise outcomes including survival, quality of life and functional independence. It also promotes good practice in decision making about treatment, consistent with the patient's preferences, values and goals of care.

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*.

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.

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. Clinical assessment and escalation will often occur simultaneously with resuscitation, diagnostic investigations and optimisation for surgery.
- 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.
- 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. (See Quality Statement 3 for more information on assessment of risk.)
- Do not delay surgical referral or review due to pending investigations, or 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.

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 (see Recommendations in the Standard for further information), 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.

Related resources for clinicians

- 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)

Box 1: Implementing the Standard in 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.

The 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.

Box 2: Transfer 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 onsite, 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 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.

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.

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. 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.

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.

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

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 preoperatively. Ensure ongoing availability to discuss findings with the surgeon as needed.

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.

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 (see Recommendations in the Standard for further information), including those related to communication and person-centred care.

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 preoperatively using brief, validated tools.

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

Preoperative 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 preoperatively 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)

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 (CFS). 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.
- **Cognitive impairment and delirium risk** (or presence): Use a brief, validated tool such as the 4AT. 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. 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.

Cultural safety and equity

Consider the cultural safety recommendations (see Recommendations in the Standard for further information) 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 for clinicians

- 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)

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.

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.

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. 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')
- Best Case / Worst Case scenarios framework.

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 utilised and readily available on the patient's healthcare record – noting that they do not replace the need for meaningful, timely discussion.

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
    - 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.

Cultural safety and equity

Consider the cultural safety recommendations (see Recommendations in the Standard for further information) 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. 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.

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, 2024)

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)

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.

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 postoperative 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.

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. 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.

Quality statement 6. Presence of consultant doctors during surgery

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

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 [RGA] 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.

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

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 an equivalent scope of practice).

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

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 ≥10% is discussed with a consultant intensivist for consideration of direct postoperative admission to critical care.

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. 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.

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 ≥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 ≥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*. 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 preoperative 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.

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.

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. 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. CGA is associated with improved outcomes for older emergency general surgery patients, including reduced mortality and length of stay.

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 postoperatively – and preoperatively 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
- 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).

Related resources for clinicians

- A framework for perioperative care in Australia and New Zealand, ANZCA 2021

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.

Before the patient leaves hospital following an emergency laparotomy:

- 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)
- 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 discharge

- Text goes here. 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
- 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 GP 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).

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, practitioner or liaison officer when this is the patient's preference.

For more information

Find out more about the *Emergency Laparotomy Clinical Care Standard* and other resources for consumers, clinicians and healthcare services.

Scan the QR code or see: safetyandquality.gov.au/el-ccs

The Australian Commission on Safety and Quality in Health Care has produced this clinical care standard to support the delivery of appropriate care for a defined condition. The clinical care standard is based on the best evidence available at the time of development. Healthcare professionals are advised to use clinical discretion and consideration of the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian, when applying information contained within the clinical care standard. Consumers should use the information in the clinical care standard as a guide to inform discussions with their healthcare professional about the applicability of the clinical care standard to their individual condition.