Clinical Excellence Division

Adult Integrated Pre-Procedure Screening Tool

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Introduction

This presentation provides an overview of the changes that have been made to the Adult Integrated Pre-Procedure Screening Tool

Background

The Adult Integrated Pre-Procedure Screening Tool is used to determine a patient's readiness for a planned surgical procedure/s.

The Screening Tool:

- Provides standardised pre-admission assessment.
- Promotes implementation of best practice prior to planned surgical procedure.

The expected benefits are to:

- Optimise a patient's health status and knowledge prior to admission for their surgical procedure.
- Provide comprehensive health screening and education prior to a patient's scheduled surgery.
- Reduce the length of stay in hospital, and to plan for the continuum of care from hospital admission through to discharge home.

Review process

- The 2017 review of the screening tool was undertaken to update clinical content to:
  - Reflect current evidence based guidelines.
  - Comply with Department of Health documentation Style Guidelines and Australian Standards for clinical records.
  - Ensure broad consultation with clinicians representative of perioperative departments.
- In addition, the latest review process has undergone format changes to streamline clinical content into a more succinct and user-friendly document.
- Overall governance for the review was through the Statewide Anaesthesia and Perioperative Care Clinical Network (SWAPNet).
- Feedback on the content was sought through SWAPNet.
- A clinical expert group was established to review the feedback and finalise the content.
- The final version (version 3.00) was endorsed by SWAPNet on 17 March 2017.

Old vs New Version

This document no longer available

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Adult Integrated Pre-Procedure Screening Tool

Patient to complete this section

Please complete and return this form to avoid any unnecessary delays in booking your surgery

General Information

Interpreter required?

Do you have any religious / cultural needs?

Are you of Aboriginal or Torres Strait Islander origin?

Do you have an Advance Health Directive?

Do you have an Enduring Power of Attorney?

Local doctor's (GP) name

Medical centre name

Do you have any allergies (medicines, sticking plaster, iodine, latex, food etc.)

Have you seen a specialist doctor or had surgery in the last 5 years?

Current Medications Taken Bring medications with you whenever you come to hospital

Page 1 of 4

New Version 3.00 – showing page 1

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Patient to complete this section

Please complete and return this form to avoid any unnecessary delays in booking your surgery

General information

Allergies

Illness / Surgical history

Major illness

Surgical history

Current medications taken (bring medications with you whenever you come to hospital)

Page 1 of 4

ADULT INTEGRATED PRE-PROCEDURE SCREENING TOOL

Major Changes – Page 1

Page 1

- ‘Have you send a specialist doctor’ heading replaced with ‘Illness/Surgical history’ heading.
- Illness and Surgical history separated into two sections.
- Surgery restriction of ‘last 5 years’ removed.
- Prompts for blood thinning medication included in medication list.

Major Changes – Page 2

Page 2

- Observations moved from page 4 to page 2.
- New Referral Pathways for staff included.
- Inclusion of the following General Health Questions:
  - Neck or jaw limiting movement
  - Dentures and loose or chipped teeth
  - Heart surgery
  - Arrhythmia or palpitations
  - Liver and kidney disease
  - Anaemia/previous blood transfusions
  - Further details for COPD/Emphysema/Lung Disease, Epilepsy and Arthritis.

Major Changes Pages 3

Page 3

- New ‘Office Use’ section.
- Infection alert moved from page 4 to page 3.
- Nutrition and skin integrity condensed.
- New ‘nurse comments’ section included.

Major Changes Pages 4

Page 4

- Inclusion of checklist with the following:
  - Patient still requires/wants surgery
  - Current health status
  - Allergies
  - MRO status
  - Weight
  - Skin integrity
  - Blood thinning medication
  - Vitamins and supplements
  - Transport
- New ‘confirmed /action taken’ and ‘patient education’ sections.
- Review by ‘nursing/medical staff’ section added.

Page 1

General Information

- This section is for the collection of information on the following:
  - Religious and cultural needs
  - Interpreter required
  - Aboriginal or Torres Strait Islander status
  - Advance Health Directive
  - Enduring Power of Attorney
  - GP Details
  - Allergies
  - Major Illnesses
  - Surgical History
  - Medications

Page 2

Health Questionnaire

- This section is for the collection of observations, relevant medical history and referral pathways.

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(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ I

Observations (staff to complete)

Weight:	Height:	BMI:	Pulse:	Blood pressure:	Temp:	Resps:	O₂ sats:	BGL:
kg	cm			/	°C		%	mmol/L

Please complete the following sections to help us to plan your care for your hospital stay

Health questionnaire

Do you have, or have you ever had, any of the following? If yes, provide further details		
1 Have you, or any of your blood relatives ever had a problem with an anaesthetic	☐ Yes ☐ No	Details:
2 Difficulty swallowing, opening your mouth or moving your neck	☐ Yes ☐ No	Details:
3 Difficulty walking up more than two flights of stairs	☐ Yes ☐ No	What stops you from walking further?
4 Dentures	☐ Yes ☐ No	☐ Upper only ☐ Lower only ☐ Both upper and lower
5 Loose or chipped teeth	☐ Yes ☐ No	Details:
6 High blood pressure	☐ Yes ☐ No	Is it controlled on medication? ☐ Yes ☐ No
7 Angina	☐ Yes ☐ No	How frequently: Details:
8 Arrhythmia or palpitations	☐ Yes ☐ No	Details:
9 Heart attack	☐ Yes ☐ No	When:
10 Heart surgery / pacemaker / defibrillator inserted	☐ Yes ☐ No	Details:
11 Other heart problem	☐ Yes ☐ No	Details:
12 Heartburn or acid reflux	☐ Yes ☐ No	Well controlled on medication? ☐ Yes ☐ No
13 Liver disease / hepatitis / jaundice	☐ Yes ☐ No	Details:
14 Kidney disease	☐ Yes ☐ No	Dialysis? ☐ Yes ☐ No Details:
15 Blood clots in the legs or lungs	☐ Yes ☐ No	Details:
16 Diabetes	☐ Yes ☐ No	Usual blood sugar level: ☐ Pre-diabetic ☐ Diet controlled ☐ Tablets ☐ Insulin
17 Asthma	☐ Yes ☐ No	How frequent are attacks? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Never Exacerbations requiring hospitalisation or close GP monitoring? ☐ Yes ☐ No
18 COPD / Emphysema / Lung disease	☐ Yes ☐ No	Frequent / recent infection / exacerbations? ☐ Yes ☐ No Details:
19 Sleep apnoea	☐ Yes ☐ No	CPAP Machine? ☐ Yes ☐ No
20 Stroke or TIA	☐ Yes ☐ No	Details:
21 Epilepsy or fits	☐ Yes ☐ No	How frequent are attacks? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly ☐ Never Details:
22 Arthritis	☐ Yes ☐ No	Are you taking steroids? ☐ Yes ☐ No Details:
23 Bleeding / bruising disorders	☐ Yes ☐ No	Details:
24 Anaemia / Previous blood transfusion	☐ Yes ☐ No	Details:
25 Have you ever smoked tobacco?	☐ Yes ☐ No	Have you smoked in last 30 days? ☐ Yes ☐ No If yes, number of cigarettes per day:
26 Do you drink alcohol?	☐ Yes ☐ No	How often?
27 Do you take recreational (party) drugs?	☐ Yes ☐ No	What do you take and how often?
28 Could you be pregnant?	☐ Yes ☐ No	How many weeks?
29 Do you suffer from anxiety, depression or emotional disorders?	☐ Yes ☐ No	Details:
30 Other medical conditions or disabilities not already mentioned	☐ Yes ☐ No	Details:
Office use: referral pathways ☐ Refer to Anaesthetist ☐ Quitline ☐ AODS ☐ Social Worker ☐ GP ☐ My Age Care ☐ Other:		

DO NOT WRITE IN THIS BINDING MARGIN

Page 3

Planning for your care

- This section is to document the care required for patients during their hospital stay and upon discharge.
- Includes skin integrity, infection alert, falls history, nutrition and nurse comments section.

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(Affix identification label here)

URN:
Family name:
Given name(s):
Address:
Date of birth: Sex: ☐ M ☐ F ☐ I

DO NOT WRITE IN THIS BINDING MARGIN

Planning for your care

Accommodation: ☐ House / Unit ☐ Hostel ☐ Boarding ☐ Retirement village ☐ Nursing home ☐ Other:
Number of stairs / steps – Front / Back: Internal:

Please answer the following questions		Office use (if **yes**, complete the following)
1 Do you live alone?	☐ Yes ☐ No	☐ Discuss with patient ☐ Refer to:
2 Do you have friends or family to help you when you leave hospital?	☐ Yes ☐ No	☐ Discuss with patient ☐ Refer to:
3 Do you have care responsibilities for others?	☐ Yes ☐ No	☐ Discuss with patient ☐ Refer to:
4 Do you have difficulty managing day to day activities?	☐ Mobility ☐ Bathing ☐ Dressing ☐ Other:	☐ Consider anaesthetist referral ☐ Communicate with ward
5 Do you have any special dietary requirements (list)?	☐ Yes ☐ No If yes, details:	☐ Discuss with patient
6 Do you have any bowel or urine problems (e.g. bleeding or incontinence)?	☐ Yes ☐ No If yes, details:	☐ Communicate with ward
7 Do you have Community support services?	☐ Community nursing ☐ Other / Name of provider: ☐ Home help ☐ Meals on wheels	☐ Consider anaesthetist referral ☐ Refer to:
8 Do you have difficulties with any of the following?	☐ Speech ☐ Hearing ☐ Touch ☐ Vision If yes, details:	☐ Consider anaesthetist referral ☐ Communicate with ward
9 Will your occupation affect your recovery / or do you need a Medical Certificate?	☐ Yes ☐ No	☐ Discuss with patient
10 How do you intend to arrive for your admission and discharge?	Admission: Discharge:	☐ Discuss with patient suitability of mode ☐ PREAC review
11 **Skin integrity:** Do you have skin problems such as sores, skin tears, bruises, blisters, rashes, dermatitis, eczema or pressure sores?	☐ Yes ☐ No If yes, details:	☐ Discuss with patient / consultant / GP ☐ OPD review ☐ Consider anaesthetist referral
12 **Infection alert:** Have you ever been placed in a private room during your hospital stay due to an infection?	☐ Yes ☐ No If yes, details:	☐ Communicate with ward
13 **Falls history:** Have you had any falls in the last 6 months?	☐ Yes ☐ No	☐ Complete full falls / frailty assessment
14 **Nutrition:** Have you lost more than 5kg over the last 6 months without trying?	☐ Yes (2) ☐ Unsure (2) ☐ No (0)	Total score: ☐ If yes or *unsure*, contact dietitian or refer to Malnutrition Action Flowchart
15 Have you been eating poorly because of a decreased appetite?	☐ Yes (1) ☐ No (0)	

Patient signature: **Date:**

Nurse comments

Page 4

Staff to complete section

- Staff to document that they confirmed the following with the patient:
  - Wants/requires surgery
  - Changes in condition or health
  - Allergies
  - MRO status
  - Current illnesses
  - Skin intact
  - Medications/vitamin supplements
  - Discharge arrangements
- Patient education
- Review sign off by nursing/medical staff

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Staff to complete this section

Surgery details

Patient education

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How to Order

OM Code	Form ID	Version	Form Title	Description in OfficeMax Catalogue
4317564	SW269	v3.00-04/2017	Adult Integrated Pre-Procedure Screening Tool	Adult Integrated Pre-Procedure Screening Tool v3.00 - SW269 (Pack of 25)

- Clinical Pathways website: http://qheps.health.qld.gov.au/caru/clinical-pathways/default.htm
- For further information and enquiries regarding Clinical Pathways, contact: Clinical_Pathways_Program@health.qld.gov.au