Fourth Patient Report of the National Emergency Laparotomy Audit (NELA)

Recommendations for Multidisciplinary Clinical Teams

It is clear from the NELA data presented in this report that there remain some crucial areas of care which must be improved if all patients undergoing emergency laparotomy are to receive the right care, by the right people, at the right time. In this 4th report there are six key themes which cover the standards against which NELA measures delivery of care for patients undergoing emergency laparotomy. For each theme there are associated actions allocated to specific owners; all are underpinned by the principles of quality improvement being specific, using measurable data from NELA, and are intended to be achievable tasks that are relevant and realistic to teams and patients within the defined time frame.

The six key NELA themes are:

1. improving outcomes and reducing complications
2. ensuring all patients receive an assessment of their risk of death
3. delivering care within agreed timeframes for all patients
4. enabling consultant input in the perioperative period for all high risk patients
5. effective multidisciplinary working
6. supporting quality improvement.

Some actions are applicable to more than one area.

	Detailed Action and Owner	Timeframe
1 Improving outcomes and reducing complications		
Maximising the value of NELA data		
1.2	**Medical Directors, Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** ensure NELA outcome data (mortality, length of stay, unplanned returns to theatre and critical care and mortality) and processes of care are presented and reviewed at regular multidisciplinary governance meetings. These meetings should consider current performance and change over time, identify gaps in care and areas of good care, and develop appropriate action plans	Commence from next governance meeting (by January 2019 at the latest)
Clinical pathways		
1.7	**Medical Directors, Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways of care that apply from admission to discharge to ensure a consistent approach to care throughout the perioperative stay. Pathways should define timelines for delivery of care, diagnosis, referral and escalation pathways, seniority of clinicians, and expectations of team members	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
Clinical care		
1.9	**Multidisciplinary clinical teams**: ensure appropriate and timely discharge planning before stepping down patients to the ward and be alert to signs of deterioration once discharged to the ward. There should be clear referral pathways for early escalation to senior clinicians of patients who are deteriorating or failing to progress. Teams should regularly review the timeliness of referrals to ensure appropriate escalation occurs promptly. Teams should ensure safe ward staffing levels exist before discharge, especially out-of-hours	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
2 Ensuring all patients receive an assessment of their risks associated with surgery that is documented in the medical record, communicated to members of the multidisciplinary team, and used to inform clinical decision-making		
2.2	**Clinical Directors, NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary pathways that ensure all patients receive a documented preoperative assessment of risk based on objective risk scoring and senior clinical judgement. This risk assessment should guide allocation of resources and subsequent delivery of care (recommendation 2.1). Where patients do not have a preoperative risk assessed and documented, they should be treated as if they are high risk patients and receive the appropriate standards of care for high risk (>5%) patients. Patients should only be treated as low risk if the multidisciplinary team agrees and documents that they can be considered low risk on the basis of clear and agreed clinical evidence	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff

2.3	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** ensure that risk assessment is based on a combination of both clinical and formal objective assessment (in particular using the NELA risk assessment tool which is more accurate than other methods for NHS patients undergoing emergency laparotomy). Risk assessment is done to facilitate the planning of care and communication and its limitations for an individual patient should always be considered. This risk assessment should be used as part of the consent process and to enable shared decision-making for high risk patients. A risk score can be easily calculated using the standalone NELA webtool and NELA risk app	January 2019
2.4	**Local NELA leads, Multidisciplinary clinical teams:** ensure that risk assessment information is communicated between all members of the multidisciplinary clinical team, including operating theatre staff, to aid joint understanding of a patient's risk and planning of care	January 2019
3 Delivering care within agreed timeframes for all patients		
Sepsis and peritonitis		
3.3	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary pathways for the management of sepsis and/or peritonitis to include patients who are admitted under non-surgical specialities. These should also ensure administration of antibiotics within 60 minutes of recognition of sepsis and appropriately rapid source control	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
3.4	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** audit and review peritonitis cases to assess own performance and pathways, benchmarking performance against national recognised sepsis pathway	January 2019
Theatre capacity		
3.9	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways to facilitate arrival of patients in theatre within appropriate timeframes, which define the roles of all team members and when they should be involved.	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
The deteriorating patient		
3.11	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways to promptly identify deteriorating patients and subsequent referral to senior decision makers in pre- and postoperative periods. This will also include those admitted under non-surgical specialties	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff

4 Enabling consultant input in the perioperative period for all high risk patients		
4.3	**Clinical Directors, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways of care for patients undergoing emergency laparotomy which are tailored to the hospital service and structure. Pathways must ensure consultants are informed, involved and lead in the care of patients undergoing emergency laparotomy throughout the care pathway. These should include escalation pathways for deteriorating patients and high risk patients such that they receive timely perioperative input into decision-making and clinical care by consultant surgeons, anaesthetists and intensivists. This should also cover the postoperative period to ensure the recognition, evaluation and management of complications which may result in unplanned return to theatre, or unplanned admission to critical care	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5 Effective Multidisciplinary Working		
Radiology		
5.2	**Radiology and Surgery Clinical Directors, Chief CT Radiographer, local NELA leads, Multidisciplinary clinical teams:** develop and agree pathways to facilitate rapid access to reported CT scanning	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
Critical Care		
5.7	**Clinical Directors from Surgery, Anaesthesia and Intensive Care, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary care pathways that include clear guidance for the clinical team as to when patients should be admitted to critical care	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5.8	**Multidisciplinary clinical teams:** ensure that NELA data on admissions to critical care and unplanned admissions to critical care are reviewed at regular multidisciplinary governance meetings, and accompanied by actions plans to improve care	Commence from next governance meeting (by January 2019 at the latest)
Elderly Care		
5.12	**Clinical Directors from Elderly Care, Surgery, Anaesthesia, Intensive, local NELA leads, Multidisciplinary clinical teams:** develop and agree multidisciplinary care pathways that define when input from Elderly Care should be sought	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5.13	**Local NELA leads, multidisciplinary clinical teams:** Ensure patients over the age of 70 have frailty, nutritional status, cognitive function and functional impairment assessed to inform decision-making and highlight those that may benefit from perioperative input by Elderly Care teams. Ensure these are embedded in clinical pathways	Pathways to be in place by April 2019 in anticipation of Best Practice Tariff
5.14	**Multidisciplinary clinical teams:** ensure that NELA data on input by Elderly Care teams is reviewed at regular multidisciplinary governance meetings	Commence from next governance meeting (by January 2019 at the latest)

6 Supporting Quality Improvement		
6.3	**NELA local leads/multidisciplinary clinical teams:** participate in regional and national quality improvement workshops, to improve understanding of QI methodology, share ideas and collaborate with other NELA teams	By 2019 as AHSN workshops are rolled out