DROP THE PRE-OP.

A toolkit for reducing unnecessary visits and investigations in pre-operative clinics

version 1.0
Don’t order unnecessary pre-transfusion testing (type and screen) for all pre-operative patients.

Canadian Society for Transfusion Medicine,
Choosing Wisely Canada recommendation #7.

Don’t perform stress cardiac imaging or advanced non-invasive imaging as a pre-operative assessment in patients scheduled to undergo low-risk non-cardiac surgery.

Canadian Cardiovascular Society,
Choosing Wisely Canada recommendation #3.

Don’t order baseline laboratory studies (complete blood count, coagulation testing, or serum biochemistry) for asymptomatic patients undergoing low-risk non-cardiac surgery.

Canadian Anesthesiologists’ Society,
Choosing Wisely Canada recommendation #1.

Don’t order a baseline electrocardiogram for asymptomatic patients undergoing low-risk non-cardiac surgery.

Canadian Anesthesiologists’ Society,
Choosing Wisely Canada recommendation #2.

Don’t order a baseline chest X-ray in asymptomatic patients, except as part of surgical or oncological evaluation.

Canadian Anesthesiologists’ Society,
Choosing Wisely Canada recommendation #3.

Don’t perform resting echocardiography as part of preoperative assessment for asymptomatic patients undergoing low to intermediate-risk non-cardiac surgery.

Canadian Anesthesiologists’ Society,
Choosing Wisely Canada recommendation #4.

Don’t perform cardiac stress testing for asymptomatic patients undergoing low to intermediate risk non-cardiac surgery.

Canadian Anesthesiologists’ Society,
Choosing Wisely Canada recommendation #5.

Avoid admission or preoperative chest X-rays for ambulatory patients with unremarkable history and physical exam.

Canadian Association of General Surgeons,
Choosing Wisely Canada recommendation #4.
Introduction

This toolkit was created to support the implementation of interventions designed to reduce unnecessary visits and decrease unnecessary investigations in pre-operative clinics. It can be used by physician groups and organizations that provide pre-operative assessments in order to optimize the process.

Make sure this toolkit is right for you

This toolkit is well suited for your institution if you have a significant number of low-risk or day-surgery patients attending your pre-operative clinic or if you have noticed significant variability in pre-operative investigation ordering practices. Research on routine laboratory testing before low-risk surgery has shown that the majority of results are normal, and less than 3% of abnormal results lead to a change in management.¹

Key ingredients of this intervention

If this description accurately reflects the current situation in your pre-operative clinic, this toolkit may help your institution reduce unnecessary pre-operative clinic visits and unnecessary investigations by introducing the following changes:

- Consensus criteria for selecting patients requiring pre-operative clinic visits
- Standardized criteria for appropriate pre-operative investigations based on patient factors, surgery factors, and inherent risk factors associated with the type of surgery performed

Establishing credible and effective leadership

A successful implementation team is a key factor in driving change and involves a group of multi-disciplinary participants representing all stakeholder groups. Credible and effective leadership is required to support the initiative and effect change. There may be times when 100% consensus is not possible, however after appropriate engagement, leaders must be able to make a reasonable decision to move forward.
**Achieving consensus among key stakeholder groups**

Achieving consensus among stakeholder groups including anesthesiologists, surgeons, internists, nurses, and office administration is a crucial step in the development and implementation of interventions. The proposed changes will require agreement on 1) the criteria for selecting which patients require pre-operative clinic visits and 2) what investigations are necessary for these pre-surgical patients.

Achieving consensus on clinical criteria for pre-operative assessments and investigations is especially important given the natural practice pattern variation that exists among members of a department. This step is critical to avoid potential same-day surgery cancellations due to perceived missing assessments/investigations because for any given patient, the pre-operative clinic consultant anesthesiologist is likely not the attending anesthesiologist on the day of surgery.

Once consensus is achieved, practice changes should be reviewed by the relevant hospital administration bodies (medical advisory committee, professional practice, etc.). This can be accomplished by supporting recommendations with evidence, where available. If no clear evidence is available, current practice can be used to establish recommendations.

Striving for a culture of improvement, positive change and innovative quality processes for patients can help drive the changes forward. Unnecessary interventions, associated wait times for tests and consultations, enduring unnecessary anxiety and aggravation are all imperatives for change.

**Implementing the Intervention**

The focus of your intervention will depend on a review of your pre-operative clinic’s current situation and an assessment of what may need to change or be enhanced. This should be part of your initial “goal-setting” exercise.

Two major components of this intervention that can provide the best and most comprehensive opportunities for change include:

1) Identifying which patients need a pre-operative clinic visit

2) Selecting investigations for pre-operative testing

Local context will determine which intervention is most appropriate, however greatest success is achieved with implementation of both initiatives. At all times, recommendations need to be specific, targeted and sensitive to the local environment in order to achieve credibility and buy-in. Identifying a contact person who is available to troubleshoot concerns on a daily basis during the implementation period is important. As a perioperative physician, an anesthesiologist (such as the one assigned to the preoperative clinic that day), would be the ideal choice.
Identifying which patients need a pre-operative clinic visit

This intervention relies on achieving consensus among surgeons and anesthesiologists around selection of patients requiring pre-operative clinic visits. These patients are typically identified based on a combination of their planned surgical procedure(s) and physiological status. An example of a pre-op clinic consultation guideline currently used to identify patients requiring a pre-operative clinic visit, or not, is provided on the next page. This clinical decision tool (CDT) is used at North York General Hospital in Toronto, mainly by surgeon’s offices to help guide decision-making at the time of surgical case booking.

If the complexity of the surgery and/or patient factors make the use of this tool difficult for the surgeon’s office, the perioperative physician in the clinic is always available to answer questions and make decisions regarding the need for a pre-operative clinic visit or other specialty consultation.
### Sample Pre-op Clinic Consultation Guideline

#### NYGH Pre-operative Clinic Consultation Guideline

(This table is intended as a guideline only)

<table>
<thead>
<tr>
<th>Surgical Category</th>
<th>Patient’s Physiological Status</th>
<th>i. Minimally invasive</th>
<th>ii. Minimal to moderately invasive</th>
<th>iii. Moderately to significantly invasive</th>
<th>iv. Highly invasive</th>
<th>v. Other Procedures</th>
</tr>
</thead>
</table>

*Ophthalmology patients undergoing lens surgery with local anesthetic and sedation do not require routine preoperative consultation*

### Medicine Consult Recommended For:

- **Coronary artery disease**
- **Type 1 or type 2 diabetes on insulin or >2 oral agents**
- **Use of aspirin, clopidogrel, ticagrelor, prasugrel, warfarin, dabigatran, rivaroxaban, apixaban or edoxaban**
- **Elevated cardiac risk (2 or more of: CAD, CHF, CKD, DM on insulin, TIA/stroke)**
- **Use of steroids (or recent taper) or immunosuppressive medications**
- **Need for endocarditis prophylaxis (undergoing GI/GU/oral procedure with history of IE, prosthetic valve, cyanotic heart disease or heart transplant)**
- **Elevated respiratory risk (asthma/COPD with recent or frequent exacerbations, ILD)**

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Abbreviations and Acronyms

CAD – Coronary Artery Disease
CHF – Congestive Heart Failure
CKD – Chronic Kidney Disease
COPD – Chronic Obstructive Pulmonary Disease
CPAP – Continuous Positive Airway Pressure
DM – Diabetes Mellitus
ENT – Ear, Nose and Throat Surgery or Otolaryngology, Head and Neck Surgery
GEN – General Surgery
GI – Gastrointestinal
GU – Genitourinary
GYN – Gynecological Surgery
ICU – Intensive Care Unit
IE – Infective Endocarditis
ILD – Interstitial Lung Disease
MI – Myocardial Infarction
OPHTHAL – Ophthalmological Surgery
ORAL – Oral and Maxillofacial Surgery
ORTHO – Orthopedic Surgery
OSA – Obstructive Sleep Apnea
PLAS – Plastic and Reconstructive Surgery
Pre-Op – Preoperative
RN – Nursing
PSYCH – Psychiatry
TIA – Transient Ischemic Attack
UROL – Urological Surgery
VASC – Vascular Surgery
Selecting appropriate investigations for pre-operative testing

A number of Choosing Wisely Canada pre-operative clinic testing recommendations are provided on page 2 and are meant to act as a starting point for change. Additional review of the literature can help identify best practice and achieve consensus among physician groups. These consensus criteria can then be translated into a pre-operative testing grid, a clinical decision tool (CDT) that identifies appropriate pre-operative investigations based on a range of factors. The following is an example of the current testing grid used at North York General Hospital in Toronto.
**Estimated Energy Requirements for Various Activities**

<table>
<thead>
<tr>
<th>Can you...</th>
<th>1 MET</th>
<th>10 METs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take care of yourself?</td>
<td>Eat, dress, or use the toilet?</td>
<td>Walk indoors around the house?</td>
</tr>
<tr>
<td>Walk a block or 2 on level ground at 2 to 3 mph (2.3 to 4.8 kph)?</td>
<td>Do light work around the house like dusting or washing dishes?</td>
<td>Climb a flight of stairs or walk up a hill?</td>
</tr>
<tr>
<td>Walk on level ground at 4 mph (6.4 kph)?</td>
<td>Run a short distance?</td>
<td>Walk on level ground at 4 mph (6.4 kph)?</td>
</tr>
<tr>
<td>Do heavy work around the house like scrubbing floors or lifting or moving heavy furniture?</td>
<td>Participate in moderate recreational activities like golf, bowling, dancing, doubles tennis, or throwing a baseball or football?</td>
<td>Participate in strenuous sports like swimming, singles tennis, football, basketball, or skiing?</td>
</tr>
</tbody>
</table>

*Modified from Hlatky et al (11), copyright 1989, with permission from Elsevier, and adapted from Retcher et al (12).
Abbreviations and Acronyms

ACE-I – Angiotensin-Converting Enzyme Inhibitor
ARB – Angiotensin II Receptor Antgonist
ASA – Acetylsalicylic Acid
BMI – Body Mass Index
CBC – Complete Blood Count
CKD – Chronic Kidney Disease
Creat – Creatinine
CXR – Chest X-Ray
DM – Diabetes Mellitus
Gluc – Glucose
G&S – Group and Screen
HTN – Hypertension
INR – International Normalized Ratio
LFTs – Liver Function Tests
Lytes – Electrolytes
METS – Metabolic Equivalents
OSA – Obstructive Sleep Apnea
Pre-op - Preoperative
PTT – Partial Thromboplastin Time
/d – Per Day
**Steps to Implementation**

1) Develop your CDT using evidence- and consensus- based criteria

2) Circulate CDT to key stakeholders and modify based on feedback

3) Use multiple avenues to inform staff about the CDT
   - Email updates
   - Posters to advertise CDT
   - Verbal updates at weekly hospital rounds and department meetings
   - Meetings/contact with referring surgeon’s administrative staff

4) Build use of CDT into day-to-day processes, make it accessible and provide reminders (paper and electronic)

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**Sample Process Map for Surgical Booking**

Source: North York General Hospital, Toronto.
PRE-OP ASSESSMENT CLINIC ORDERS

CONSULTS:
(Please indicate reason for consult AND include all relevant reports with chart e.g. cardiology, respirology, neurology etc.)

☐ Anesthesiology ______________________________________
☐ Internal Medicine _____________________________________
☐ CCAC
☐ Enterostomal
☐ Other _____________________________________________

BOWEL PREPARATION:
(if yes, specify) _________________________________________

INVESTIGATIONS:
☐ Follow Standardized Testing Grid
☐ Number of cross-matched units: _________________________

Other:
☐ HbA1C  ☐ βhCG
☐ Ferritin  ☐ Sickle Cell screen

Hip arthroplasty (Xray pelvis with hip in 20 degree internal rotation and lateral of hip):
☐ Right  ☐ Left

Knee arthroplasty (Xray knee):
☐ Right  ☐ Left
☐ AP  ☐ Lateral  ☐ Skyline  ☐ AP 4 feet standing

☐ Fax Rehabilitation papers to St. John's
☐ Other _______________________________________________

DAY OF SURGERY ORDERS

PREOPERATIVE ANTIBIOTIC:
☐ Vancomycin 500 mg  1 hour pre-op
☐ Vancomycin 1000 mg IV  1 hour pre-op

ANTITHROMBOTICS:
(Anesthesiologist to administer anticoagulant in Operating Room)
☐ Compression stockings (TED)
☐ Other _______________________________________________

SAME DAY INVESTIGATIONS:
☐ Glucose
☐ INR
☐ Other _______________________________________________

☐ Repeat G&S if previous sample was taken ≥ 30 days ago

PREOPERATIVE ANALGESICS:
This section must be signed below
On arrival to Day Surgery
Acetaminophen ☐ 1000 mg  PO x1
Celecoxib ☐ 200mg  ☐ 400mg POx1
Gabapentin ☐ 100mg  ☐ 300mg  ☐ 600mg POx1

Other:________________________________________________

Physician Signature: ____________________________________
Date: _________________________________________________
Time: _________________________________________________

PHYSICIAN’S SIGNATURE (Applies to Pre-op clinic and or Day of Surgery orders except for the section on Pre-operative analgesics)

Posted by Pre-op Assessment Clinic Nurse:

Posted by Day of Surgery Nurse:

Source: North York General Hospital, Toronto.
Note: “Follow standardized testing grid” box is pre-checked!
Measuring your performance

Choose a family of measures

The following are common measures used to evaluate appropriate selection of patients for pre-operative consultations and appropriate pre-operative investigations.

1) Primary measures: These are the main improvements that you are trying to achieve.
   - Number of patients attending pre-operative clinic (there should be a reduction in the number of lower-risk patients attending the clinic, and a resultant shift in the overall patient population of the clinic towards higher-risk categories. Thus, overall patient volumes may not necessarily decrease, but case-mix will change).
   - Number of investigations ordered in pre-operative clinic (these should decrease as only necessary investigations are ordered).

2) Process measures: These measures are developed to ensure that each aspect of the intervention is being carried out and delivered as intended.
   - Number of providers using the standardized criteria for patient selection
   - Number of providers using consensus criteria for pre-operative testing

3) Balancing measures: Any intervention may create new unintended consequences that need to be measured.
   - Number of re-scheduled or delayed procedures due to perceived missing investigations and/or sub-optimally worked-up medical conditions found on day of surgery

Determine a collection method

There are many ways to measure successful implementation of a CDT in your institution. Several methods can be used:

A) Clinic Scheduling System (this can be used to provide further detail if the number of patients for each procedure type can be tracked)
   - Count the number of patients attending pre-operative clinic in a specified time frame and compare to number of patients attending clinic exactly one year prior

B) Formal or Informal Surveys
   - Count the number of staff who are currently using the CDTs in their practice versus total staff surveyed

C) Financial Evaluation
   - Consider a cost-savings analysis of potential money, time, resources, etc. saved from avoiding un-necessary clinical time and laboratory costs
   - Consider a costs-incurred evaluation of balancing measures outlined in step 3 above
Sustaining early successes

Once the intervention to reduce unnecessary visits and testing in the pre-operative clinic has been implemented and refined, there are several important ways to help sustain this performance.

1) The CDTs used to select patients for pre-operative clinic visits or appropriate pre-operative investigations should be easily accessible and built into day-to-day processes. This can be done by leveraging your order sheet to include a reminder and a copy of the CDT, and modifying processes to include your CDT.

2) Updating the CDT to ensure alignment with current evidence and guidelines over time will help promote best practices and continued use. Setting regular intervals for ongoing review is helpful in keeping the CDT up to date.

Additional resources

Health Quality Ontario, *Quality Compass*, an evidence-informed tool designed to support leaders and providers as they work to improve health care performance

(http://qualitycompass.hqontario.ca/portal/getting-started#.VqJNBsd6wUg)

Institute for Healthcare Improvement, *How to Improve*, a quality improvement resource based on IHI’s model for improvement

(http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx)

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