RECOGNISING AND PREVENTING DELAYED DISCHARGES - THE ROLE OF THE PAIN SERVICE IN PREOPERATIVE ASSESSMENT

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Introduction

Day case surgery has been on the rise thanks to newer surgical techniques combined with advances in anaesthesia. Inadequately controlled pain after elective day case surgery can result in unplanned admissions, delayed discharges and can erase any financial advantages. Anaesthesia preoperative assessment services are now an essential part of the planned care pathway, often improving patient experience with good outcomes, alongside improved efficiency and productivity. Discharge planning is an integral process of the preoperative assessment, but pain related complex cases can sometimes go unrecognised and contribute to delayed discharge. We present a case report of an elderly lady with complex persistent pain and social issues who was admitted for an elective day case hand surgery.

Case Report

A 76 year old lady was admitted for an elective day case surgery.

Procedure : Removal of metalwork from left wrist, plus fusion plus bone graft.

Past Medical History: Wrist osteoarthritis/ hypertension/ asthma/ anxiety & depression/ chronic obstructive pulmonary disease (COPD).

Past Surgical History: She had 4 previous surgeries on the same hand over the last 12 years with no long lasting improvement in pain and patient related outcome measures. Metalwork was implanted 3 years previously.

Previous surgery also planned as a day case. This resulted in an extra 2 weeks in hospital postoperatively due to pain and mental health related issues. These events were not identified in the preoperative assessment. No information was communicated to the pain team regarding the complexity of this patient.

At the time of surgery, metalwork was removed and fusion with bone grafting was done with standard perioperative anaesthesia (GA plus LA infiltration). Patient woke up in severe pain, unresponsive to routine postoperative pain management strategies, resulting in an unplanned admission. Over the next week, she was seen by the inpatient pain services daily and the physiotherapy team. There was no improvement in quality of pain relief despite pharmacological measures. No surgical issues identified.

Following a Pain Consultant led ward round, it transpired that the patient had no reliable social support available for discharge, the patient was waiting for a relative to take them home. There was significant reluctance from the patient to return home unaided which resulted in an unplanned bed occupancy (6 days). Pain was less of an issue than anticipated on review. The clinical expectation of complete pain relief were also revised in view of her history and a long overdue discussion was held with the patient's relative regarding the plan. The patient was discharged home the next day with the relative.

Issues Identified:

1. Decision for surgery taken by junior surgeon. No MDT done
2. Previous history of multiple surgeries with inadequate clinical outcomes not identified
3. Previous surgery 3 years ago had also resulted in unplanned admission for 2 weeks
4. Previous surgery also planned as day case
5. Social circumstances not identified
6. Persistent pain not treated adequately

Improvement Measures

We have encouraged preoperative assessment nurses to communicate earlier with us regarding complex patients.

We are organising education/training regarding recognition of persistent pain for preoperative department

We provided the pre-op department with appropriate referral criteria regarding complex cases and high opioid use.

We have created a common email id for the inpatient pain team and made an electronic referral form for easy referral to the pain team by pre-op department or surgeons for complex cases.

Discussion

Early recognition of complex persistent pain patients can help in planning their in-patient journey and facilitate good discharge planning, thus reducing the risk of chronic post surgical pain.

This case highlights the fact that inpatient pain services can play an integral part in the preoperative assessment of patients with pain related complex care needs.

Inpatient pain services are often able to put in place a comprehensive holistic treatment plan including discharge planning.

In such times of austerity, this has the potential to reduce pressure on hospital beds and increase patient flow/capacity.

On-going discussions include making an inpatient pain nurse available to sit in preoperative assessment

Conclusions

Pain related unplanned admissions can be prevented.
Early and effective communication between pain team and preoperative assessment is very useful.
Education of healthcare professionals on persistent pain recognition and management is vital
Inpatient pain services can play a vital role in perioperative management of complex patients