SESLHD GUIDELINE COVER SHEET

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FUNCTIONAL GROUP(S)	Surgery, Perioperative and Anaesthetic
KEY TERMS	Metabolic, disorder, bariatric, bariatric surgery, obesity
SUMMARY	This guideline outlines the referral and management processes for obese patients from SESLHD requiring surgical intervention. It outlines the ANZMOSS inclusion and exclusion criteria.

SESLHD GUIDELINE COVER SHEET

Model of Care for SESLHD MDBSS

Section 1 - Background

The growing incidence of obesity is one of the most challenging contemporary threats to global public health. The prevalence of obesity is increasing across the globe and in 2017-18 Australia ranked fifth among Organisation for Economic Co-operation and Development OECD countries with over a third (31%) of Australians living with obesity.(1)

Obesity is defined as a chronic relapsing progressive disease characterized by an abundance of body fat. Obesity has been identified as the major contributing factor for serious chronic diseases including type two diabetes mellitus, cardiovascular disease, hypertension, stroke, osteoarthritis, obstructive sleep apnoea and certain forms of cancer (2 p 3)

The 2013 NHMRC systematic review found that “Bariatric surgery is more effective than other treatment options in achieving weight loss in adult and adolescent patients with obesity”. Bariatric surgery has important effects on metabolic disease, not simply weight loss.(3)

Bariatric surgery is a very safe and effective way to treat patients with chronic obesity, evidenced by long term significant and sustained weight loss as well as decreased overall mortality (4). Bariatric Surgery is proving to be a highly effective treatment for improving the above for mentioned co-morbidites as well as having a significant improvement to quality of life (5).

Section 2 – Definitions

Body Mass Index (BMI)

Obesity is defined according to Body Mass Index (BMI). BMI is calculated by dividing weight in kilograms (kg) by the height in metres squared (m^2). A graded classification system which is based on the World Health Organisation (WHO) weight categories can be used to interpret BMI for adults aged 18 years and over and is as follows (6):

Classification	BMI (kg/m^2)	Risk of Co-Morbidities
Underweight	<18.5	Low (but risk of other clinical problems increased)
Normal Range	18.5 – 24.9	Average
Overweight	25 – 29.9	Increased
Obese Class I	30 – 34.9	Moderate
Obese Class II	35 – 39.9	Severe
Obese Class III	>40	Very severe

Edmonton Obesity Staging System (EOSS)

The limitations of relying only on BMI to prioritise patient for surgery is that it fails to distinguish between muscle and fat and overall patient health. The Edmonton obesity scale (EOSS) is a risk stratification tool that assigns patients living with obesity a score that predicts their specific risk of mortality. EOSS will also be used to reflect those with the greatest comorbidity. See below EOSS stage definitions (7 page 7)).

Stage 0 – No apparent obesity-related risk factors (e.g. blood pressure, serum lipids, fasting glucose, etc. within normal range), no physical symptoms, no psychopathology, no functional limitations and/or impairment of well-being

Stage 1 – Obesity-related subclinical risk factor (s) (e.g. borderline hypertention, impaired fasting glucose, elevated liver ensymes, etc.), mild physical symptoms (e.g., dyspnoea on moderate exertion, occasional aches and pains, fatigue, etc.), mild psychopathology, mild funtional limitations and/or mild impairment of well-being.

Stage 2 – Established obesity-related chronic disease(s) (e.g. hypertention, type 2 diabeties, sleep apneoa, osteoarthritis, reflux disease, polycyctic ovary syndrome, anxiery disorder, etc.), moderate limitations in activites of daily living and/or well-being.

Stage 3 – Established end-organ damage such as myocardial infarction, heart failure, diabetic complications, incapacitating osteoarthritis, signigficant psychopathology, significant funtional limitation(s) and/or impairment of well-being.

Stage 4 – Severe (potentially end-stage) disability/ies from obesity-related chronic diseases, severe disabling psychopathology, severe funtional limitation(s) and/or severe impairment of well-bieng.

Section 3 – Aim

The aim of the Metabolic Disorders and Bariatric Surgery Service (MDBSS) is to provide a supported pathway to bariatric surgery within the South Eastern Sydney Local Health District (SESLHD).

The service has three main roles:

1. ***To assess if surgery is safe and appropriate for the candidate.***
   Candidates will be assessed using an eligibility and prioritisation criteria. A pre-surgical optimisation program will be completed by candidates prior to being listed for surgery. This program will provide education to ensure the candidate can make an informed decision in regards to bariatric surgery.

   The service will ensure that candidates deemed not appropriate for surgical management of their obesity will be referred to appropriate services for ongoing care; such as the NSW Get Healthy Program and community bases services such as dietitians, psychologists, exercise physiologist or relevant specialist services.

2. ***To encourage sustainable healthy lifestyle changes to prepare the candidate for life after bariatric surgery.***
   The pre-surgical optimisation program will provide healthy lifestyle education. The candidate is expected to implement learnings from this program and show evidence of change before they can proceed for surgery.

3. ***To provide multi-disciplinary support to candidate post-surgery.***
   The service with provide multi-disciplinary support post-surgery and transition candidates to Primary health care providers for long term follow-up.

Section 4 – Principals of Care

This model of care reflects the Public Bariatric Surgery National Framework released in October 2020 by the Australian and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS) and Collaborative Public Bariatric Taskforce (11). This Framework is complementary to the first National Framework for Clinical Obesity Services in Australia (10) developed by National Association of Clinical Obesity Services (NACOS)

This National Framework has been designed to deliver.

- Efficient patient centred care.
- Sustainable use of resources to cater to the disease burden of obesity in the community.
- Deliver surgical care to the most appropriate patient populations.

To provide care and facilities that align with a patient centered interprofessional approach in a non-judgmental environment with emphasis on obesity as a chronic condition and not as a condition of personal failure.

Section 5 - Referral Pathway

5.1 REFERRAL PROCESS

SESLHD Metabolic Disorders and Bariatric Surgery Service is an outpatient service that will provide a pathway to bariatric surgery patients within the SESLHD. Eligible patients will need to be referred by a specialist. GPs will also be a vital link in the care of the patient on their journey through the program during both the pre-operative and post-operative phases.

Specialist must complete a referral form and Bariatric Surgical Screening assessment. These forms can be obtained by contacting the service coordinator via email, (See appendix A)

SESLHD-MetabolicBariatricSurgricalService@health.nsw.gov.au or phone 9113 4515.

Referrals will be assessed according to eligibility and prioritisation criteria as per consensus reached at the taskforce meeting for public bariatric surgery framework in table 1 and 2 below

All referrals received will be discussed at the MDT meeting.

Patients deemed ineligible for entering the SESLHD bariatric surgical program will be referred back to their referring specialist and general practitioner for consideration of alternative treatment options.

5.2 ELIGIBILITY, PRIORITISATION AND EXCLUSION CRITERIA

The SESLHD criteria are aligned to principles in the Australia and New Zealand Metabolic and Obesity Surgery Society (ANZMOSS) Public Bariatric National Framework. It is based on a disease model, where bariatric surgery provides for amelioration of the underlying disease.

ELIGIBILITY CRITERIA:

Table 1: ANZMOSS National Framework Eligibility criteria Summary (11 page 3)

Eligibility criteria	Contraindications
• Aged 18-65, BMI >35-40, EOSS 2-3 AND • Documented previous weight loss attempts/treatments. • Absence of contra indications (see next column)	If the patient in review has any one or more of the following contraindications, they will not be eligible for bariatric surgery: • Medical contraindications for surgery after risk assessment • Alcohol/illicit drug dependence • Untreated severe depression • Untreated DSM-5 eating disorders not managed by appropriate healthcare professional(s) • Active psychosis
OR	
• Age 18-65, BMI >40, EOSS 1-3 AND • Documented previous weight loss attempts/treatments. • Absence of contraindications (see next column)	
OR	
• Aged 65-70, BMI >40, EOSS 2-3 AND • Documented previous weight loss attempts/treatments. • Absence of contraindications (see next column)	
Diabetes	
• BMI>30-35 AND had T2DM for <10years or has favourable C-Peptide level (*) which is poorly controlled with medications. • BMI >35 with established diabetes	

EXCLUSION CRITERIA

These criteria are based on recommendations from the ANZMOSS and Collective Pubic Bariatric Surgery Taskforce (11 page 7)

- EOSS 0 regardless of BMI (all referral with a BMI of >40 will be screened for undiagnosed obesity related co-morbidities)
- EOSS 4 regardless of BMI (end stage organ damage – with the exception of planned transplant recipients)
- Age >70 Age <18
- Current Smokers. Smokers need to complete a 6 month smoking cessation program with view to permanent cessation prior to surgery. This is due to the associated increased operative morbidity, risk of poor wound healing and gastric ulceration (11 page 3)
- Medical contraindications for surgery after risk assessment
- Alcohol/illicit drug dependence
- Untreated severe depression
- Untreated DSM-5 eating disorders not managed by appropriate healthcare professional(s)
- Active psychosis

PATIENT PRIORITY GROUPS

Priority for assessment and surgery will be given to patients with significant chronic disease that is not currently well managed with medical therapy and there is evidence that the condition responds to weight loss (11 page 23)

Table 2: ANZMOSS National Framework priority groups (11 page 24)

First priority group	Second priority group
First priority group for urgent assessment and timely surgery if appropriate: Note not all patients assessed will be offered surgery as the recommended treatment. Conditions in this category may include individuals aged 18-65 with a BMI > 50 or BMI >40 with: - Poorly controlled Type 2 diabetes - Obesity hypoventilation syndrome with significant symptoms and disability.* - Weight related idiopathic intracranial Hypertension (IIH) (typically seen in premenopausal women)* - Polycystic ovary syndrome and/or obesity related infertility* - Heart failure, limited to those with preserved ejection fraction and diastolic dysfunction.* - Non-alcoholic steatohepatitis with evidence of Stage 1-3 fibrosis (those with compensated cirrhosis should also be considered.* - End-stage renal disease necessary pre-conditioning for renal transplant - End stage liver disease necessary pre-conditioning for liver transplant* - Major physical dysfunction in patient requiring arthroplasties * - Patients with established stable cardiovascular disease (including hypertension, heart failure, and coronary artery disease)*	**Second priority group**: This cohort would be prioritised for bariatric metabolic surgery with BMI 40-50 (BMI 30-40 with type 2 diabetes); or following an inadequate response to nonsurgical weight loss therapy in the BMI range 35-40 with: - Type 2 diabetes - NASH – without evidence of significant fibrosis* - Obesity hypoventilation syndrome* - Polycystic ovary syndrome and/or obesity related infertility* - Metabolic cardiac dysfunction cardiomyopathy* - High risk of IHD with multiple risk factors not responding to established medical therapy - Major weight responsive psychological mental impairment (EOSS 3) - Major weight responsive physical disability (EOSS 3)

* Groups at very high risk with strong theoretical and observational evidence of benefit, but convincing evidence is limited. These conditions should be monitored within specific registry projects. SESLHD MDBSS contributes data to the Bariatric Surgery Register (BSR).

5.3 PREOPERATIVE PATHWAY

Compulsory Introductory Education Session

Eligible candidates will be given an appointment to attend a compulsory introductory education session. The purpose of the introduction session is to prepare the candidate for the referral process and provide a summary of dietary requirements and surgical options. It ultimately allows the candidate to decide if they want to proceed. Following this session patients will be asked to sign a memorandum of understanding (MOU). This is to ensure that the candidates are aware of the proposed flow through the referral process as well as a good understanding of their role in ensuring they progress through the referral pathway.

Clinical assessment

Candidates that elect to continue in the program will be comprehensively assessed from a medical, surgical, nutritional, psychological and social point of view. These assessments guide management and are educative opportunities for the patient.

Patients will be assessed by Clinical Nurse Consultant, Dietitian, General Physician and the Bariatric Surgeon.

The multidisciplinary team will:

- Address problems identified by the patient and referring specialist.
- Identify cause of weight gain, where possible
- Refer patient to relevant specialist and allied health services.

Nutritional Assessments

- Patients will have their weight, BMI, fat percentage, fat mass, fat free mass and muscle mass recorded using Bioelectrical Impedance Analysis (BIA) scales.
- Waist circumference will also be recorded.
- Weight history will be explored include current weight, previous weight, reason for weight changes, duration of weight changes and previous weight loss attempts including what interventions have worked before e.g. pharmacology and lifestyle programs.
- Previous dietitian involvement.
- Usual diet and food habits (timing, frequency and size), eating attitudes and behaviors.
- Screen for evidence of disordered eating.
- Identify readiness for change / level of motivation and barriers to change
- Goal setting.
- Development of an appropriate diet plan and nutritional intervention.

Compulsory group sessions and follow-up appointments

All eligible candidate will go through a pre-operative education program. This will include group education and personalised education/health coaching during follow-up clinic appointments.

Candidates will be required to attend a number of individual and 4 compulsory group education sessions focusing on healthy diet, exercise and lifestyle choices. Sessions will be scheduled on a regular cycle to enable patients to attend 'missed' sessions.

Group and individual sessions will be conducted face to face and via telehealth.

Patients will be required to show evidence of implementation of lifestyle and dietary changes during the pre-surgical optimization phase. Patient will be required to keep a food and exercise diary. Patient who fail to implement changes and who continue to gain weight during this phase will be discussed at MDT and may be discharged from these service.

The MDT may allocate the patient a weight loss goal prior to being considered a candidate for surgery.

Patients that are consistently miss multiple group education sessions and follow-up appointments will be discussed at the MDT meeting and may be discharged from the service. The referring specialist, GP and patients will be notified via written correspondence of their discharge from the service as well as recommendations for future care.

5.4 PROGRESSION TO SURGERY

Not all patients referred to the service who meet criteria will be deemed suitable for surgery.

Following completion of compulsory group sessions and compliance with follow-up appointments patients will be discuss at the MDT meeting.

Patients will be considered for surgery if they demonstrate evidence of:

1. Healthy lifestyle behavior change
2. Regular attendance at follow-up appointment
3. Evidence of stable weight / weight loss
4. Confidence from MDT that they will comply with the follow-up requirements such as vitamin and mineral supplementation.

The whole MDT must agree that the patient is a suitable candidate for surgery. Any member of the MDT may veto progression to surgery (due to medical, psychological or other reasons). Patients found not suitable will be referred back to referring specialist and GP with advice on how to proceed.

Patients deemed suitable for Bariatric surgery will be reviewed by the Bariatric Surgeon. The Bariatric Surgeon in consultation with the patient will determine type of bariatric surgery to be completed taking into account the patients comorbidities and weight / BMI.

A Request For Admission (RFA) form will be completed at time of surgical consultation pending any issues arising during consultation. The patient will be required to submit the RFA to St George Hospital. The RFA will be managed as per NSW Health Waitlist Policy (12) (3 month waitlist).

Patients will be required to be on a Very Low Energy Diet (VLED) for a minimum of 2-4 weeks preoperatively as determined for dietitian and surgeon. Failure to comply with the VLED may result in the patients operation being postponed.

5.5 POST OPERATIVE PATHWAY

Patients will follow the Gastric Sleeve / Gastric Bypass Clinical Pathway. See Appendix B

Patients will be admitted for 1-3 days pending the following discharge criteria;

- Unstable diabetes
- No complaints of nausea or vomiting
- Tolerating > 1 Litre of fluids within 24 hours
- Pain well controlled with oral analgesia
- No abdominal distention
- Wounds clean and dry, dressings intact
- Body Temperature <38°C
- Dietitian r/v
- CNC review + Discharge Education

Post-op surgical management will be coordinated by Upper GI team. Medical management will be coordinated by General Medical team.

5.6 POST- DISCHARGE FOLLOW-UP

Pathology
Routine labs and nutrient screening will be conducted at 3 months, 6-9 months and 12 months post-surgery as per the American Society for Metabolic and Bariatric Surgery Integrated Health Nutritional Guidelines for the Surgical Weight Loss Patient 2016 (13) and Update and Clinical practice guidelines for the perioperative nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures – 2019 update (14)

Bone Mineral density (BMD) test
Patient over 50 will have two years post-operatively.

Follow-up appointments
Patients will be reviewed post operatively by the MDT as per the table below. Patients will be reviewed frequently in the acute post-operative stages and gradually transitioned to primary health providers for ongoing care. Patient will be monitored by the service for up to 24 months post-surgery.

1-2 Weeks	Phone call from Bariatric CNC
2 Week	Dietitian r/v
4 Week	Dietitian r/v
6 Weeks	Dietitian and Surgeon

3 Months	CNC, Dietitian and Physician as required
6 Months	CNC, Dietitian and Physician as required
12 Months	CNC, Dietitian and Physician as required
18 Months	CNC, Dietitian and Physician as required
24 Months	CNC, Dietitian and Physician as required

Section 6 – Data collection

Bariatric surgery will improve the health and wellbeing of patients with Class II and Class III obesity. The evidence suggests that it will lead to weight loss and improvement of obesity related diseases such as:

- Type two diabetes mellitus
- Hypertension
- Hypercholesterolemia
- Cardiovascular disease
- Sleep apnoea
- Musculoskeletal complaints

SESLHD MDBSS will collect data from the pre-operative and annual follow-up to 24 months post-op. This data will include a comorbidities screen, Depression, Anxiety and Stress Scale (DASS), Epworth sleepiness scales and Quality of life data using Short Form 36 Health Survey (SF-36).

The service will also contribute data to the Bariatric Surgery Registry (BSR). The BSR aims to improve patient care and outcomes from bariatric surgery. The BSR tracks the safety, and the effect bariatric surgery has on long-term health in Australia and New Zealand.

Section 7 – Governance Framework

The Metabolic Disorder Bariatric Surgery Service Governance Committee structure involves representatives from all facilities in SESLHD including General Managers, Surgeons, Physicians, Allied Health and General Practitioners to ensure equity of access to the service.

The Committee will monitor costs and ensure accountability of funding expenditure and equitable access across SESLHD. The committee will be supported by the Monash University based Bariatric Surgery registry to monitor the service and evaluate and measure outcomes of both the metabolic and surgical stage of the program.

The MDT reports to the Governance Committee which will report every 3 months to the SESLHD Clinical and Quality Council.

Section 8 - Location of Services

SESLHD Metabolic Disorders and Bariatric Surgical Service is an outpatient service. Clinics will be run in the Aged care department, 3 Chapel Street Kogarah.

Group education sessions will be run out of either the Research and Education Centre at St George Hospital or the Chapel Street Aged Care Department. Telehealth Sessions will also be utilised where appropriate to improve access to care for patients.

Section 9 – References

1. World Health Organisation. Obesity and Overweight. Fact Sheet No 311. From: http://www.who.int/mediacentre/factsheets/fs311/en/. Body mass index (BMI) is used to classify overweight and obesity. WHO defines overweight as having a BMI equal to or greater than 25, and obese as having a BMI equal to or greater than 30.

2. *Using the Edmonton obesity staging system to predict mortality in a population-representative cohort of people with overweight and obesity*. Padwal RS, Pajewski NM, Allison DB, Sharma AM. 14, 2011, CMAJ, Vol 183, ppE1059-1066

3. NHMRC 2013. Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia – SYSTEMATIC REVIEW.

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6. World Health Organisation. Obesity : preventing and managing the global epidemic : report of a WHO consultation. (WHO technical report series 894) 2000 : Geneva, Switzerland. https://apps.who.int/iris/handle/10665/42330

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8. *Bariatric Surgery: risks and rewards,* Pories WJ, 93, 2008, Journal of Clinical Endocrinology and Metabolism, Vol 11, S89-S96

9. *Advances in the Science, Treatment, and Prevention of the Disease of Obesity: Reflections From a Diabetes Editors* Expert Forum. Cefalu WT et al. 8 2015, Diabetes Care, Vol. 38, pp. 1567-82

10. *National Framework for Clinical Obesity Services.* National Association of Clinical Obesity Services Victoria: NACOS, 2020, Vol. First Edition.

11. *Public Bariatric Surgery A National Framework.* ANZMOSS and Collaborative Public Bariatric Surgery Taskforce, 2020

12. NSW Health PD2012_011 Waiting Time and Elective Surgery Policy

13. *American Society for Metabolic and Bariatric Surgery Integrated Health Nutritional Guidelines for the Surgical Weight Loss Patient 2016 Update: Micronutrients.* Parrott, J et al. 2017, Surgery of Obesity Related Diseases

14. *Clinical practice guidelines for the perioperative nutrition, metabolic, and nonsurgical support of patients undergoing bariatric procedures – 2019 update: cosponsored by American Association of Clinical Endocrinologists/American College of Endocrinology, The Obesity Society, American Society for Metabolic & Bariatric Surgery, Obesity Medicine Association, and American Society of Anesthesiologists.* Mechanich, J. I et al, 2020, Surgery for Obesity and Related Diseases, Vol 16, pp 175-247

15. NSW Health GL2018_012 Work Health and Safety- Management of Patients with Bariatric Needs

Revision and Approval History

Date	Revision no:	Author and approval
May 2021	DRAFT	Initial draft by J McAfee. Draft for comments period.
June 2021	0	Endorsed by Executive Sponsor.
July 2021	0	Tabled at SESLHD Clinical and Quality Council
July 2021	1	Approved at Clinical and Quality Council.

Appendix A:

Health
South Eastern Sydney
Local Health District

Facility:

METABOLIC DISORDERS AND BARIATRIC SURGERY REFERRAL

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

SES010438

Please Fax to 9113 3979 or email SESLHDMetabolicBariatricSurgeryService@health.nsw.gov.au

INCLUSION CRITERIA

☐ Specialist Consultant Referral

☐ BMI >35kg/m²

☐ Patients must have one or more of the following obesity related comorbidities:

- Diabetes mellitus type 2
- Non-alcoholic steatohepatitis
- Obstructive sleep apnea
- Quality of life limiting joint disease
- Other significant functional disorder e.g. hernia

PATIENT DETAILS

GP Name/Phone number: _____

Patient Email: _____

☐ Yes - Aboriginal
☐ Yes - Torres Strait Islander
☐ Yes - Both
☐ Neither ☐ Unknown

Language Spoken: _____

Interpreter required: □Yes □ No

Medicare number: _____/_____

REASON FOR REFERRAL

CLINICAL INFORMATION

Allergies: _____ Smoker: ☐ Yes ☐ No

Medical History:

Current Medications:

Social History:

Investigations (eg. recent serology, previous dietitian report) Please attach

Referring Doctor (print): _____ Date: _____/_____/_____

Signature: _____

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Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

BARIATRIC SURGERY SCREENING ASSESSMENT

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Date: / /		**Referring Specialist:**
Weight:	**Height:**	**BMI (kg/m²):**

Previous attempts to lose weight: All appropriate non-surgical measures should have been tried but failed to achieve or maintain adequate, clinically beneficial weight loss. Please provide evidence of weight loss attempts with referral.		
Diet and exercise program	☐ **Yes**	☐ **No**
Dietitian consultation	☐ **Yes**	☐ **No**
Participation in formalised weight loss program eg Weight Watchers, Lite'n'Easy, Jenny Craig	☐ **Yes**	☐ **No**
Meal replacement program	☐ **Yes**	☐ **No**
Obesity related Co-morbidities: Priority will be given to patients with significant chronic diseases known to respond well to weight loss. Patient must have one or more of the following conditions.		
Type II Diabetes Mellitus	☐ **Yes**	☐ **No**
Hypertension	☐ **Yes**	☐ **No**
Obstructive sleep apnoea	☐ **Yes**	☐ **No**
Pulmonary hypertension	☐ **Yes**	☐ **No**
Non-alcoholic steatohepatitis (fatty liver)	☐ **Yes**	☐ **No**
Osteoarthritis	☐ **Yes**	☐ **No**
Other (provide details)		
Surgical Risk: If the patient has any of the following medical conditions bariatric surgery may be contraindicated.		
Active Cancer	☐ **Yes**	☐ **No**
Unstable heart or lung disease	☐ **Yes**	☐ **No**
Current Smoker – must be ceased 6mths prior to surgery	☐ **Yes**	☐ **No**
Advanced liver disease with portal hypertension	☐ **Yes**	☐ **No**
Uncontrolled obstructive sleep apnoea with pulmonary hypertension	☐ **Yes**	☐ **No**
Serious blood or autoimmune disorders	☐ **Yes**	☐ **No**
Mental Health and Cognitive Status: Patients must be able to give fully informed consent and commitment to the program. Patients with any of the following conditions should have appropriate interventions prior to referral. Please provide evidence of interventions with referral.		
Active psychosis or unstable psychiatric disorder	☐ **Yes**	☐ **No**
Severe untreated depression	☐ **Yes**	☐ **No**
Current alcohol dependence	☐ **Yes**	☐ **No**
Current illicit substance use disorder	☐ **Yes**	☐ **No**
Cognitive or behavioural disorders affecting decision-making	☐ **Yes**	☐ **No**
Past or current history of eating disorder eg binge eating disorder, anorexia, bulimia etc.	☐ **Yes**	☐ **No**

Referring Specialist provider number:	**Signature:**

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BARIATRIC SURGERY SCREENING ASSESSMENT SES060.133

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Appendix B

Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL PATHWAY SLEEVE GASTRECTOMY/ GASTRIC BYPASS

SES060207

To be completed in Pre-admission clinic		Completed
Investigations & Assessements completed. Results available	VTE Assessment Completed / Recorded Eg: Bloods, Imaging OR as per Pathway requirements	
Observations	Dr's instructions on referral form noted & actioned Pressure Risk Assessment attended Waterlow score: _____ Blood glucose recorded for all patients Referral to Dietitian In Accordance with SAGO and NSW Ministry of Health	
Patient has clear expectations prior to admission	Patient understands Preoperative Orders Shower the night before surgery Advised to cease smoking (if applicable)	
Patient understands Nutrition/ Diet	Dex. Carbohydrate drink: x 2 the day of surgery up until 2 hours prior to surgery Patient understands they will receive text message or phone call with pre-operative fasting times.	
Patient understands post-operative pathway	Procedure Consent form signed ☐ Yes ☐ No Patient information booklet given to patient with explanations Patient aware of key pathway, discharge criteria & length of stay Patient aware of Rights and Responsibilities & consumer feedback process Informed that any questions/queries will be answered	
Patient understands pain management	Patient understands the VAS and NRS pain score. Patient is aware of importance of reporting post-op pain Pain management discussed & understood by patient	
Patient understands medication requirements	Regular medication list recorded in patient notes. Regular medication recorded and taken as per anaesthetic order Anticoagulants, NSAIDS, Aspirin & fish oil ceased 7 days prior to surgery Patient understands the importance of VTE prophylaxis Patient advised to bring in medications in original packing	
Patient understands discharge instructions	Discharge destination identified: _____ Discharge time 10am: transport organised Continue to wear graduated elastic compression stockings until follow up appointment with surgeon Confirm Discharge Planning with Patient and Family	

Nurse sign: _____ Print: _____

Date: _____ / _____ / _____ Time: _____ : _____

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CLINICAL PATHWAY
SLEEVE GASTRECTOMY/GASTRIC BYPASS
SES060.207

Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL PATHWAY SLEEVE GASTRECTOMY/ GASTRIC BYPASS

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	Post op Day 0:	AM	PM	ND
PACE	PACE Tier 1 Activated			
	PACE Tier 2 Activated			
Observations	Post op orders checked and implemented			
	Post-op observations T,P, R, BP and Sa02 4 hours then 4/24 if stable and alert			
	Humidified Airflow Therapy or CPAP if prescribed			
	Routine bloods (FBC/UEC) only required if clinically indicated			
	BGL within normal limits (if required)			
Hygiene	Ambulate to bathroom with assistance			
Wounds/ Drains	Wound Check			
	Drain/s insitu Site:			
Pain Management	Aim for pain score of less than 4: If >4 administer analgesia Post-op pain management discussed and understood by patient			
	Regular Paracetamol QID or as charted			
Nutrition/ Diet	Sips of Water/ice to suck			
	Dietitian referral			
	Sugar free chewing gum TDS			
Intravenous Therapy/ Access	Device: Position: VIP:			
Elimination	IDC removal (unless contraindicated) ☐ Yes ☐ No ☐ NA			
	Flatus ☐ Yes ☐ No			
	Bowel motion ☐ Yes ☐ Type ☐ No			
Physiotherapy/ Mobilisation	4 hours post-op hang legs over the side of the bed Sit out of bed 10-20 mins as tolerated			
VTE Prophylaxis	Compression stocking ☐ Yes ☐ No/Not Suitable			
	VTE Prophylaxis charted as per local guidelines and administered			
	If applicable commence enoxaparin education			
Handover of care Alerts noted and all charts checked				

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NO WRITING

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Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL PATHWAY SLEEVE GASTRECTOMY/ GASTRIC BYPASS

	Post op Day 1:	AM	PM	ND
PACE	PACE Tier 1 Activated			
	PACE Tier 2 Activated			
Observations	Standard Observations			
	Nocte CPAP if prescribed			
	No Pathology required unless clinically indicated			
	BGL within normal limits (if required)			
Hygiene	Ambulate to bathroom with assistance			
Wounds/ Drains	Wound Check			
	Drain/s insitu Site: ☐ N/A			
Pain Management	Aim for pain score of less than 4: If >4 administer analgesia			
	Regular Paracetamol QID or as charted			
Nutrition/ Diet	Sugar free chewing gum TDS			
	FLUID – clear Bariatric (Non fizzy) approx. 125ml/hr aiming for 1000-1500ml per day			
Intravenous Therapy/ Access	Device: VIP:			
Elimination	Remove IDC (unless contraindicated) ☐ Yes ☐ No ☐ N/A			
	Flatus ☐ Yes ☐ No			
	Bowel motion Type			
Physiotherapy/ Mobilisation	SOOB for meals ☐ Breakfast ☐ Lunch ☐ Dinner			
	SOOB min 2 hours x 2 (4 hours total) ☐ 2 hours ☐ 2 hour			
	Walk min 1000 steps (approximately 30 minutes)			
VTE Prophylaxis	VTE Prophylaxis charted as per local guidelines and administered			
	Compression stockings ☐ Yes ☐ No/Not suitable			
Discharge Criteria/ Planning	No complaints of Nausea or vomiting ☐ Yes ☐ No			
	Tolerating >1Litre of fluids within 24 hours ☐ Yes ☐ No			
	Pain well controlled with oral analgesia ☐ Yes ☐ No			
	No abdominal distention ☐ Yes ☐ No			
	Wounds clean and dry, dressings intact ☐ Yes ☐ No			
	Body Temperature <38◦c ☐ Yes ☐ No			
	Dietician r/v + D/C education ☐ Yes ☐ No			
	CNC r/v + D/C education ☐ Yes ☐ No			
	Sent home with paperwork, medications and appointments provided ☐ Yes ☐ No			
Handover of care Alerts noted and all charts checked				

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NO WRITING

Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL PATHWAY SLEEVE GASTRECTOMY/ GASTRIC BYPASS

SES060207

	Post op Day 2:	AM	PM	ND
PACE	PACE Tier 1 Activated			
	PACE Tier 2 Activated			
Observations	Standard Observations			
	Nocte CPAP if prescribed			
	Routine bloods (FBC/UEC) only required if clinically indicated			
	BGL within normal limits (if required)			
Hygiene	Ambulate to bathroom with assistance			
Wounds/ Drains	Wound Check			
	Drain/s insitu Site: ☐ N/A			
Pain Management	Aim for pain score of less than 4: If >4 administer analgesia			
	Regular Paracetamol QID or as charted			
Nutrition/ Diet	Sugar free chewing gum TDS			
	FLUID – full Bariatric (Non fizzy) approx. 125ml/hr aiming for 1000-1500ml per day			
Intravenous Therapy/ Access	Device: VIP:			
Elimination	Remove IDC (unless contraindicated) ☐ Yes ☐ No ☐ N/A			
	Flatus ☐ Yes ☐ No			
	Bowel motion Type			
Physiotherapy/ Mobilisation	SOOB for meals ☐ Breakfast ☐ Lunch ☐ Dinner			
	SOOB min 3 hours x 2 (6 hours total) ☐ 3 hours ☐ 3 hour			
	Walk min 1500 steps (approximately 45 minutes)			
VTE Prophylaxis	VTE Prophylaxis charted as per local guidelines and administered			
	Compression stockings ☐ Yes ☐ No/Not suitable			
Discharge Criteria/ Planning	No complaints of Nausea or vomiting ☐ Yes ☐ No			
	Tolerating >1Litre of fluids within 24 hours ☐ Yes ☐ No			
	Pain well controlled with oral analgesia ☐ Yes ☐ No			
	No abdominal distention ☐ Yes ☐ No			
	Wounds clean and dry, dressings intact ☐ Yes ☐ No			
	Body Temperature <38◦c ☐ Yes ☐ No			
	Dietician r/v + D/C education ☐ Yes ☐ No			
	CNC r/v + D/C education ☐ Yes ☐ No			
	Sent home with paperwork, medications and appointments provided ☐ Yes ☐ No			
Handover of care Alerts noted and all charts checked				

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NO WRITING

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Health
South Eastern Sydney
Local Health District

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CLINICAL PATHWAY SLEEVE GASTRECTOMY/ GASTRIC BYPASS

	Post op Day 3:	AM	PM	ND
PACE	PACE Tier 1 Activated			
	PACE Tier 2 Activated			
Observations	Standard Observations			
	Nocte CPAP if prescribed			
	Routine bloods (FBC/UEC) only required if clinically indicated			
	BGL within normal limits (if required)			
Hygiene	Ambulate to bathroom with assistance			
Wounds/ Drains	Wound Check			
	Drain/s insitu Site:			
Pain Management	Aim for pain score of less than 4: If >4 administer analgesia			
	Regular Paracetamol QID or as charted			
Nutrition/ Diet	Sugar free chewing gum TDS			
	FLUID – full Bariatric (Non fizzy) approx. 125ml/hr aiming for 1000-1500ml per day			
Intravenous Therapy/ Access	Device: VIP:			
Elimination	Remove IDC (unless contraindicated) ☐ Yes ☐ No ☐ N/A			
	Flatus ☐ Yes ☐ No			
	Bowel motion Type			
Physiotherapy/ Mobilisation	SOOB for meals ☐ Breakfast ☐ Lunch ☐ Dinner			
	SOOB min 4 hours x 2 (8 hours total) ☐ 4 hours ☐ 4 hour			
	Walk min 2000 steps (approximately 60 minutes)			
VTE Prophylaxis	VTE Prophylaxis charted as per local guidelines and administered			
	Compression stockings ☐ Yes ☐ No/Not suitable			
Discharge Criteria/ Planning	No complaints of Nausea or vomiting ☐ Yes ☐ No			
	Tolerating >1Litre of fluids within 24 hours ☐ Yes ☐ No			
	Pain well controlled with oral analgesia ☐ Yes ☐ No			
	No abdominal distention ☐ Yes ☐ No			
	Wounds clean and dry, dressings intact ☐ Yes ☐ No			
	Body Temperature <38◦c ☐ Yes ☐ No			
	Dietician r/v + D/C education ☐ Yes ☐ No			
	CNC r/v + D/C education ☐ Yes ☐ No			
	Sent home with paperwork, medications and appointments provided ☐ Yes ☐ No			
Handover of care Alerts noted and all charts checked				

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NO WRITING