Section 5: Day surgery services

Edited by
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### Patient information before day surgery

**Mr D Ralphs**

<table>
<thead>
<tr>
<th>Why do this audit?</th>
<th>Unless advice is timely, comprehensive and comprehensible, patients will not be adequately prepared for their admission. This may result in unnecessary anxiety, increased overnight admission rate and increased contact with community clinicians.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Best practice: research evidence or authoritative opinion</strong></td>
<td>Both oral and written information must be given to the patient. It should be given sufficiently far in advance of admission to allow for assimilation, questioning and action by the patient. Good practice advice in preparation and use of written patient information should be followed. Written information should be in the first language of the patient. Written information posted on the web is welcomed by an increasing number of patients. This incidentally may heighten the profile of day surgery. Also refer to audit 1.1 on patient information about anaesthesia.</td>
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<tr>
<td><strong>Suggested indicators</strong></td>
<td>Existence of a protocol for pre-admission assessment that includes guidance for information giving. Patients should receive verbal and written information in their first language at least 2 weeks before surgery. Verbal information may be given at a pre-admission clinic or by telephone if the patient does not attend the clinic.</td>
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<tr>
<td>% procedures carried out in the day unit for which a suitable information leaflet exists.</td>
<td></td>
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<tr>
<td>% of leaflets meeting criteria for good practice.</td>
<td>5,6</td>
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<tr>
<td>% patients who receive information prior to admission as follows, either verbally or written or both:</td>
<td></td>
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<tr>
<td>- general information on how the unit works and what to expect (e.g. arrival time, time of surgery, arrangements for food and drink, likely pick up time).</td>
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<tr>
<td>- specific information about the procedure to be performed including common complications and expected period of incapacity afterwards.</td>
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<td>- information about preoperative fasting time for food and for fluids.</td>
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<tr>
<td>- information about the anaesthetic type, its risks and side effects.</td>
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<tr>
<td>- information about analgesics to be used and the possible use of suppositories, or a regional or local block.</td>
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<tr>
<td>% patients who are satisfied with the information which they received when questioned 7 days after surgery.</td>
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<tr>
<td><strong>Proposed standard or target for best practice</strong></td>
<td>There should be a protocol as described above.</td>
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<tr>
<td>100% leaflets should meet criteria for good practice</td>
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</tr>
<tr>
<td>100% patients should receive, at least 2 weeks before admission, written and verbal information under all of the headings above which are relevant to the procedure.</td>
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<tr>
<td>95% patients should be satisfied with the information which they received.</td>
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</tbody>
</table>
### Suggested data to be collected
- Existence of protocol.
- Arrangements for giving both verbal and written information.
- Leaflets – existence, content with respect to national standards.¹, ²
- Questions to determine satisfaction with the elements of information giving included in satisfaction surveys.
- Reasons for dissatisfaction may point to issues for quality improvement.

### Common reasons for failure to reach standards
- Lack of leaflets for all procedures.
- Information given only in English.
- Lack of consistency.
- Verbal information not thought important.

### Related audits
1.1 – Patient information about anaesthesia

### References
Pre-admission assessment

Dr I Smith

Why do this audit?

Preoperative assessment is an essential element of a high-quality and efficient day surgery service. Appropriate pre-assessment improves the patient’s experience of day surgery by providing information about the proposed operation and giving the opportunity to ask questions. In addition, timely pre-assessment reduces patient cancellations and failure to attend (DNA). Two-thirds of all day surgery cancellations are made by the patient.

Best practice: research evidence or authoritative opinion

There should be local agreement on which procedures may be performed as day surgery. The decision on whether a specific patient listed for any of these procedures is managed as a day case, short stay or in-patient should be made at pre-assessment, unless there is a surgical contraindication to day surgery in that patient. Pre-assessment should be performed by trained nurses, supported by anaesthetists; the process should be protocol-driven and structured questionnaires are useful in data collection. Assessment should be based on social and medical criteria, according to recent guidelines and agreed with the anaesthetic department. Absolute arbitrary cut-offs (such as age and weight) are increasingly considered inappropriate; day surgery should be the norm unless there is a specific contraindication.

Assessment should be performed in time to correct any abnormalities and allow the patient to be adequately informed and prepared for surgery. While there are advantages to centrally assessing all patients for elective surgery, many feel pre-assessment for day surgery is better performed by specialist day surgery nurses on the unit where surgery will subsequently take place.

Suggested indicators

Existence of an agreed protocol for pre-assessment that has been reviewed in the last 2 years by a multidisciplinary team.

% patients having day surgery under general anaesthesia who have been pre-assessed according to this protocol at least 2 weeks prior to admission.

% patients having intermediate procedures under local anaesthesia (e.g. inguinal hernia repair) who have been pre-assessed as above.

Of patients who underwent pre-assessment, % found to be unsuitable for day surgery at the time of surgery and which could or should have been detected at pre-assessment.

% of patients failing to attend or cancelling within 2 days of surgery.

Proposed standard or target for best practice

Existence of a pre-assessment protocol as above.

100% of both groups of patients described above should have been pre-assessed at least 2 weeks prior to surgery according to the agreed protocol.

0% of patients who have been pre-assessed should have (pre-existing) problems discovered later which make them unsuitable for day surgery.

DNA and late cancellation rates should be below about 5% and/or show a year-on-year reduction.
### Suggested data to be collected
- Evidence of the protocol and the date of last review by a multidisciplinary group.
- Date of pre-assessment and date of surgery.
- DNA and late cancellation rate.
- Where cancellation occurs on the day of surgery, the reasons for this and whether or not it was due to something which could or should have been discovered at pre-assessment.

### Common reasons for failure to reach standards
- No protocol for pre-assessment, failure to regularly review and update it, failure to apply the protocol.
- Patients added to the list at too late a stage to attend pre-assessment (suggest notify day surgery unit and perform telephone pre-assessment).
- Protocol applied unevenly between specialties (or even individual consultants within a specialty).
- Patients admitted to wards not dedicated to day surgery.

### Related audits
1. 3 – Pre-admission clinics

### References
Adequacy of postoperative pain relief after discharge
Dr I Jackson, Dr P Gandhimani

Why do this audit?
Day surgery is a key strand of NHS modernisation and the Department of Health target for day surgery is that it should account for 75% of all elective surgery. More complex and challenging procedures such as laparoscopic cholecystectomy and fundoplication are now being performed as day cases. Thus the major proportion of surgical patients will be recovering at home and have reduced assessment of the adequacy of their pain relief. However, there is also evidence that many operations categorised as minor can result in severe pain and a recent literature review showed that 45% of day case patients experience pain at home. Unrelieved pain has adverse physiological consequences, delays healing and is a risk factor for development of chronic pain. Pain at home also has economic implications with increased demand on community health services and delayed return to daily activities and employment.

Best practice: research evidence or authoritative opinion
Evidence suggests that pain following day surgery is a problem in both adults and children. Patients' low expectations may well contribute to this problem (studies show that 48% think it is part of healing and 39% see it as something to be endured). This may reduce the number of patients actually using the analgesic medication prescribed for them.

Suggested indicators
- % patients discharged with regular analgesics.
- % patients discharged with verbal and written instructions about pain control.
- % patients with verbal pain score of 'severe' in the first 48 h after discharge.
- % patients achieving a verbal pain score of 'mild' or 'none' with medication after discharge.
- % patients satisfied with management of their pain while at home.
- % given written instructions on what to take once supplied analgesia pack is finished.

Proposed standard or target for best practice
- 100% patients discharged with regular analgesics.
- 100% patients discharged with verbal and written instructions about pain control.
- < 5% reporting 'severe' pain on verbal pain score in the first 48 h after discharge.
- > 85% reporting no pain or mild pain after discharge (with medication).
- > 85% satisfied with the management of their pain while at home.
- 100% given instructions on what to take once analgesia pack finished.
Day surgery services

Suggested data to be collected

Day of surgery collect:

- Anaesthetist, operation, whether discharged with a working local block (e.g. penile or ilio-inguinal block), analgesia prescribed to take home.

At 24/48 h collect:

- Verbal pain score, whether using medication, whether discharged with written and verbal instructions, degree of relief provided by medication, satisfaction with management of pain.

Common reasons for failure to reach standards

- Failure to supply analgesia.
- Failure to recognise severity of pain experienced following procedure.
- Failure to adhere to clinical guidelines for treatment of postoperative pain.
- Failure of patient education, i.e. to take the analgesics supplied.

References

5. McGrath B et al. Thirty percent of patients have moderate to severe pain 24 hr after ambulatory surgery; a survey of 5,703 patients. Can J Anaesth 2004;51(9):886–891.
Day surgery theatre utilisation

Dr B Watson

Why do this audit?

The Department of Health has set a target of 75% of elective surgery being carried out on a day case basis. There are good reasons to think that this is achievable in most trusts. However, many trusts have limited dedicated day case facilities. It is therefore crucial that day surgery lists are utilised optimally if trusts are to achieve maximum day case rates. Achieving optimum rates of surgery managed on a day case basis will have beneficial effects on day surgery and in-patient waiting times.

Day surgery is, by its very nature, almost exclusively elective work and many of the most frequently performed operations are of fairly predictable duration. This should allow lists to be planned and carried out with a high degree of efficiency.

Best practice: research evidence or authoritative opinion

The Audit Commission has compared theatre utilisation in different trusts to targets for elective, trauma and emergency work. This report contains details of different measures of theatre utilisation. The NHS Modernisation Agency has published tools for improving theatre efficiency, in addition to examples of case studies. The Association of Anaesthetists has also published guidance concerning efficient use of theatre time.

Suggested indicators

Theatre utilisation (defined as actual run time of lists as percentage of their session planned hours).

Late starts, early finishes and long gaps within lists.

Proposed standard or target for best practice

Theatre utilisation target is 90%.

Less than 10% of lists should have utilisation of > 100%.

Less than 10% of lists should have utilisation of < 80%.

100% of lists should start within 15 mins of planned start time.

Less than 10% of lists should have an unplanned gap of > 10 min during the session.

Suggested data to be collected

For each booked list: arrival times of medical staff, start and finish times for each case, reasons for late starts, early finishes and gaps within lists.

Common reasons for failure to reach standards

Lists under- or overbooked. Templates may need review.

Cancellation of patients on the day of surgery.

Medical staff unavailable.

Equipment shortages.

Training issues.

Failure of patient to attend.


**Day surgery services**

**Related audits**

13.4 – Maintenance of a consultant-based service and appropriate list allocation to trainees

13.5 – Assistance for anaesthesia

**References**


Discharge protocols

Dr A Lipp

Why do this audit?

The proper use of agreed discharge criteria is important for safe and effective discharge.

Best practice: research evidence or authoritative opinion

A written discharge policy is recommended for patient comfort, safety and for medico-legal reasons. An assessment of the patient’s readiness for discharge is essential and following this, discharge by nursing staff is acceptable. Criteria for discharge may vary depending on the procedure and anaesthetic technique used. All patients should receive written information in a language they understand. This should be procedure specific, highlighting the expected outcome of surgery, possible complications and postoperative telephone number.

Suggested indicators

1. Existence of a protocol for discharge similar to that described in references 2, 3 and 4.
2. % of patients who achieve agreed discharge criteria prior to discharge.
3. % of patients with pain scores indicating control of pain using analgesic methods which continue to be available after discharge.
4. % of patients who have written instructions on discharge.
5. % of patients who have a contact telephone number for a health professional on discharge.
6. % of patients who are satisfied with the arrangements for discharge.
7. % of patients in whom there is evidence that discharge home was not satisfactory. This may include use of the contact telephone number for advice or instructions which could have been given prior to discharge, early contact with a community health professional or readmission.

Proposed standard or target for best practice

A protocol should exist as above. Indicators 2 to 6 above should be true for 100% patients. Indicator 7 above should be as low as possible, ideally 0%.

Suggested data to be collected

Data collection as above from the discharge check-list and by telephoning the patients at home 24 h after discharge. Reasons for use of contact telephone number; contact with health professional or readmission and whether avoidable or unavoidable in the opinion of the auditor.

Common reasons for failure to reach standards

Failure to adhere to the discharge policy.
Inadequate explanation given.
Misjudgement of the degree of pain likely to be experienced at home.
Failure to realise that social support was not adequate.
Day surgery services

References

Unplanned hospital admission after day surgery

Dr M Stocker

Why do this audit?

Unplanned admission after day surgery is inconvenient for patients and their carers. Admission of these patients increases the pressure on acute hospital beds. With the introduction of payment by results day cases which are admitted may cost more than the tariff payment.

High unplanned admission rates may reflect sub-optimal practice in a variety of areas, evaluation of this will highlight areas for development. Identification of high admission rates and subsequent changes in practice will have great benefits for patient care and organisational efficiency.

Best practice: research evidence or authoritative opinion

There should be protocols in place for appropriate patient selection and perioperative management. Admission and readmission rates should be regularly evaluated and efforts made to take steps to improve these where appropriate. There are only a few published standards for unexpected admission; for example in urology the Royal College of Surgeons has suggested readmissions should be < 3%.

Suggested indicators

Existence of defined medical and social day surgery exclusion criteria.

Protocols for management of anaesthesia, analgesia and anti-emesis.

% patients requiring unexpected admission and reasons for this.

Evidence that admission rates are regularly evaluated.

% patients readmitted within 48 h of discharge (for problem linked with original procedure).

Proposed standard or target for best practice

Existence of agreed protocols as above.

100% of patients should meet agreed criteria.

Targets for readmission after discharge should be set locally and continually refined. For consideration:

- < 2% unplanned admission rate
- < 0.5% readmission after discharge.

Suggested data to be collected

Evidence of protocols in place.

Assessment of patient suitability against protocols.

Assessment of clinical practice against protocols.

Admission rates, reasons, clinical outcome; opportunities for improvement.

Readmission – emergency admission data linked to previous surgical episode.
Day surgery services

Common reasons for failure to reach standards

- No protocol, or protocols not applied — unsuitable patients, procedures, medical/nursing practice.
- Skill and experience of surgeon and anaesthetist.
- Lack of dedicated day surgery unit and staff, day cases using in-patient theatres or wards.

References and further reading


Further reading
