

## Section 5: Day surgery services

Edited by Dr Ian Jackson

- 5.1 Patient information for day surgery
- 5.2 Pre-admission assessment
- 5.3 Adequacy of post-operative pain relief after discharge
- 5.4 Day surgery theatre utilisation
- 5.5 Discharge protocols
- 5.6 Unplanned hospital admission after day surgery
- 5.7 Anaesthetic patient reported outcomes in day surgery

## 5.1

## Patient information for day surgery

Dr I R Armstrong

**Why do this audit?**

The NHS plan of 2000 laid down a commitment to improving patient information and this has been reinforced by groups such as the Picker Institute and the Patient Information Forum.<sup>1</sup> Each of the Royal Colleges has its own Patient Liaison Group.

**Best practice: research evidence or authoritative opinion**

The NHS Institute for Innovation and Improvement stresses the importance of both verbal and written information and the need to address particular groups of patients such as the young, incapacitated and patients whose first language is not English.<sup>2</sup> The AAGBI and the British Association of Day Surgery have produced a consensus document on Day Surgery which includes details of patient information, again emphasising the need for timely information given in simple terms in the patient's first language.<sup>3</sup> This information needs to include both general information about how the unit works and what to expect, as well as information specific to the proposed procedure.<sup>4</sup>

**Suggested indicators**

- D Guidelines on the provision of patient information as part of the care pathway.
- D Written general information about how the unit works.
- D Information about fasting, general and regional anaesthesia including any risks involved.
- D Information on post-operative analgesia.
- D The % of procedures carried out as day cases with written information which should include common complications and the expected period of incapacity.
- D The % of this written information with specified review dates.
- D Follow up data about patient expectations and experience.

**Proposed standard or target for best practice**

- D There should be a protocol detailing the above indicators.
- D 90% of day surgery procedures undertaken should have a procedure specific information pack and all should have a review date.
- D All patient should receive the information at a point which allows adequate time for assimilation and questions to be asked, before the procedure.
- D 95% of patients should have their expectation met on follow up.

**Suggested data to be collected**

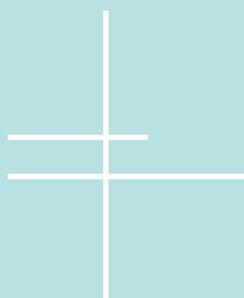
- D Adherence to a protocol within the care pathway for providing information which is both general in nature and procedure specific, with review dates.
- D Follow up questions to patients about their experience, the information provided, their expectations and whether these were met.

**Common reasons for failure to meet standard**

- D Lack of written information for all procedures.
- D Lack of information for specific patient groups such as young, incapacitated or in languages other than English.
- D No follow up data about the patient experience.

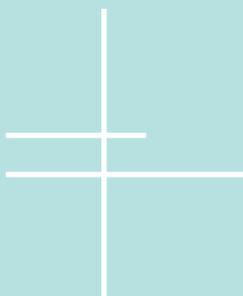
**CPD and Curriculum mapping**

CPD matrix codes: **1105, 2A03, 2G01**



## References

- 1 The NHS Plan: A plan for investment, a plan for reform. *DH*, London 2000 ([http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4002960](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4002960)).
- 2 Quality and service Improvement Tools – Patient Information. *NHS Institute for Innovation and Improvement*, 2008 ([http://www.institute.nhs.uk/quality\\_and\\_service\\_improvement\\_tools/quality\\_and\\_service\\_improvement\\_tools/patient\\_information.html](http://www.institute.nhs.uk/quality_and_service_improvement_tools/quality_and_service_improvement_tools/patient_information.html)).
- 3 AAGBI and BADS. Guidelines on Day Case and Short Stay Surgery. *Anaesthesia* 2011;**66**:417–434.
- 4 Patient Information Toolkit. NHS Brand guidelines 2010 (<http://www.nhsidentity.nhs.uk/tools-and-resources/patient-information>).



## 5.2

## Pre-admission assessment

Dr I Smith

**Why do this audit?**

Pre-operative assessment is an essential element of a high-quality and efficient day surgery service. This is a two way process in which information is both gathered, to aid medical evaluation and optimisation prior to surgery, and provided, to prepare the patient for the day surgery episode and manage their expectations.<sup>1,2</sup> Appropriate pre-operative assessment improves the patient's experience, reduces anxiety, provides an opportunity to answer questions and reduces cancellations on the day of surgery.<sup>1,2,3</sup>

**Best practice: research evidence or authoritative opinion**

There should be local agreement on which procedures may be performed as day surgery. Day surgery should be the default choice for these procedures, but specific patients may be moved to a short stay or in-patient pathway during the pre-operative assessment. Pre-operative assessment should be performed by trained nurses, supported by consultant anaesthetists;<sup>3</sup> the process should be protocol-driven<sup>4</sup> and structured questionnaires are useful in data collection.<sup>5</sup> Assessment should be based on social and medical criteria according to recent guidelines,<sup>5</sup> agreed with the anaesthetic department. Arbitrary cut-offs (such as age and weight) are inappropriate; day surgery should be the norm unless there is a specific contraindication.<sup>5,6</sup> Pre-operative assessment should be performed in time to correct any abnormalities and allow the patient to be adequately informed and prepared for surgery; provision of a 'one-stop' service on the day of the surgical outpatient appointment is ideal.<sup>2</sup> While there are advantages to centrally assessing all patients for elective surgery, experts and patients prefer pre-operative assessment for day surgery to be performed by specialist day surgery nurses on the unit where surgery will subsequently take place.<sup>7</sup>

**Suggested indicators**

- D Existence of an agreed protocol for pre-assessment which has been reviewed in the last two years by a multidisciplinary team.
- D % patients having day surgery under general anaesthesia who have undergone pre-operative assessment according to this protocol at least two weeks prior to admission.
- D % patients having intermediate procedures under local anaesthesia (e.g. inguinal hernia repair) who have undergone pre-operative assessment as above.
- D Of patients who underwent pre-operative assessment, % who have this on the same day as their surgical outpatient appointment (one-stop pre-operative assessment).
- D Of patients who underwent pre-operative assessment, % found to be unsuitable for day surgery at the time of surgery and which could or should have been detected at pre-operative assessment.
- D % patients failing to attend or cancelling within two days of surgery.

**Proposed standard or target for best practice**

- D Existence of a pre-assessment protocol as above.
- D 100% of both groups of patients described above should have undergone pre-operative assessment at least two weeks prior to surgery according to the agreed protocol.
- D 50% of patients should have had pre-operative assessment on the same day as their surgical out-patient appointment (one-stop service).
- D 0% patients who have undergone pre-operative assessment should have (pre-existing) problems discovered later which make them unsuitable for day surgery.
- D DNA and late cancellation rates should be below 5% and/or show a year-on-year reduction.

**Suggested data to be collected**

- D Evidence of the protocol and the date of last review by a multidisciplinary group.
- D Date of pre-operative assessment and date of surgery.
- D DNA and late cancellation rate.
- D 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-operative assessment.

### Common reasons for failure to meet standard

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

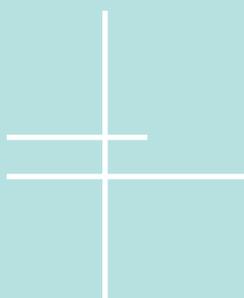
### CPD and Curriculum mapping

CPD matrix codes: **2A03, 3A06**

Training curriculum: **Annex B (DS\_BK\_01), Annex C (DS\_IK\_03), Annex D (DS\_HK+01), Annex (DS\_AK\_02)**

### References

- 1 National good practice guidelines on pre-operative assessment for day surgery. *NHS Modernisation Agency*, 2002.
- 2 Organisational issues in pre-operative assessment for day surgery. *British Association of Day Surgery*, London 2010.
- 3 Pre-operative assessment and patient preparation — the role of the anaesthetist 2. *AAGBI*, London 2010 (<http://www.aagbi.org/sites/default/files/preop2010.pdf>).
- 4 Day surgery — a good practice guide. *NHS Modernisation Agency*, 2004.
- 5 Verma R et al. Day case and short stay surgery: 2. *Anaesthesia* 2011;**66**:417–434 (<http://www.aagbi.org/sites/default/files/Day%20Case%20of%20web.pdf>).
- 6 Ten dilemmas in preoperative assessment for day surgery. *British Association of Day Surgery*, London 2009 (<http://www.bads.co.uk>).
- 7 Lewis S et al. A patient survey to determine how day surgery patients would like preoperative assessment to be conducted. *J One-day Surg* 2009;**19**(2):32–36.



## 5.3 Adequacy of post-operative pain relief after discharge

Dr S Wasawo

### Why do this audit?

There are an increasing number of operations that are deemed suitable for day case and are incentivised as such.<sup>1,2</sup> The procedures are becoming more complex but it should be remembered that relatively minor procedures can be associated with an inordinate amount of pain. A recent survey has shown that patients are most worried about vomiting followed by pain post-operatively.<sup>3</sup> Uncontrolled pain has several adverse reactions that include, in the short term, emotional and physical suffering, sleep disturbance, cardiovascular effects, and decreased mobility which promotes thromboembolism.<sup>4</sup> In the longer term, post-operative pain can lead to chronic pain and behavioural changes in children that can last up to a year.<sup>4</sup> It is imperative that we give adequate pain relief to assure patients that going home is a safe and comfortable alternative. Previous observations have noted that patients prefer day case surgery but felt post-operative instruction was inadequate leading to distress.<sup>5</sup>

### Best practice: research evidence or authoritative opinion

Pain following surgery remains a problem.<sup>3</sup> <5% of patients experiencing severe pain in the 48 hours post-operatively is a generally accepted standard of care. There is evidence that some services have further reduced this to 1% or 2%, this more challenging target may serve to drive improvement towards excellence.

Pain following surgery may be predicted by factors such as pre-operative pain, anticipated post-operative pain by the clinician, pre-operative high expectations of the patient, younger age and fear of short-term consequences of the operation.<sup>6</sup>

Good quality pain relief will result in earlier mobilisation, reducing the 'social cost' in terms of returning to work and reduce intervention by primary care.

Many day surgery units no longer supply free take home medication.

### Suggested indicators

- D % patients with written and oral instructions about pain control.
- D % patients with verbal pain score of 'severe' in the first 48 hours.
- D % patients achieving pain score of 'mild' or 'none' after discharge.
- D % patients satisfied with pain management at home.

### Proposed standard or target for best practice

- D 100% patients discharged with written and oral instructions regarding pain relief.
- D <5% reporting 'severe' pain on verbal pain score in the first 48 hours after discharge.
- D >85% reporting 'none' or 'mild' pain after discharge.
- D >85% satisfied with management of their pain at home.

### Suggested data to be collected

- D Anaesthetist.
- D Operation.
- D Planned anaesthetic (include regional and local used).
- D Written and verbal post-operative analgesia plan.
- D Regular and break through analgesia.
- D At 6, 24 and 48–72 hours:
  - ◆ verbal pain score
  - ◆ if using regular analgesia
  - ◆ effectiveness of analgesia
  - ◆ satisfaction of pain management.

### Common reasons for failure to meet standard

- D Failure of patient education – need for regular pain relief.
- D Failure to follow local post-operative analgesic guidelines.
- D Failure to appreciate severity of post-operative pain.
- D Failure to prescribe adequate sufficiently potent take home medication.

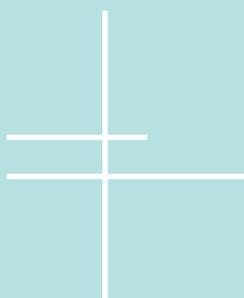
### CPD and Curriculum mapping

CPD matrix codes: ID01, 2E01, 3A06

Training curriculum: Annex B pages B-23,(PO\_BK\_07, PO\_BK\_13) B-43, B-44 (DS\_BK\_04, DS\_BK\_10, DS\_BS\_03), Annex C page C-20 (DS\_IK\_01–04)

### References

- 1 BADS directory 3rd Edition. British Association of Day Surgery, London June 2009 (<http://www.bads.co.uk>).
- 2 Department of Health Payment by Results (PbR) best practice tariffs 2011–2012.
- 3 Eberhart LHJ et al. Patient preferences for immediate postoperative recovery. *Br J Anaesth* 2002;**89**(5):760–761.
- 4 Post Operative Pain Management – Good Clinical Practice. *European Society of Regional Anaesthesia and Pain Therapy* (<http://www.esraeurope.org/PostoperativePainManagement.pdf>).
- 5 Mooney G, Symonds A. 'They just said come in for a day': patients' experiences of day case surgery. *Primary Health Care Research and Development* 2001;**2**:55–56.
- 6 Gramke et al. Predictive factors of postoperative pain after day-case surgery. *Clin J Pain* 2009;**25**(6):455–460.



## 5.4

## Day surgery theatre utilisation

Dr I R Armstrong

**Why do this audit?**

Theatre utilisation defined simply as the actual run time as a percentage of the planned session time is used as a performance marker. The limitations of this are now recognised as regular over-runs will indicate a high utilisation but hide the resources and costs incurred in over-runs. Equally, low utilisation may hide failures in other parts of the pathway. Theatre utilisation has to be viewed as part of the overall patient pathway and significant factors which will influence theatre utilisation include bed availability, staffing and cancellations. Day surgery by its nature is currently almost exclusively planned work which is largely predictable in duration. This should allow optimal utilisation of theatre time as part of the pathway taking into account the optimal utilisation of the other pathway resources.

**Best practice: research evidence or authoritative opinion**

The Audit Commission reviewed theatre utilisation with hospital comparisons, detailed different measures of utilisation and set some targets.<sup>1</sup> Guidance on efficient use of operating theatre time together with further definitions has been set out by the Association of Anaesthetists.<sup>2</sup> Most recently, the NHS Institute for Innovation and Improvement has launched the Productive Operating Theatre Programme which sets out a number of useful modules aimed at optimising the utilisation of the patient pathway.<sup>3</sup>

**Suggested indicators**

- D Theatre utilisation: actual run time as a percentage of planned run time.
- D Late starts, long gaps within lists.
- D Cancellation rates, categorised.

**Proposed standard or target for best practice**

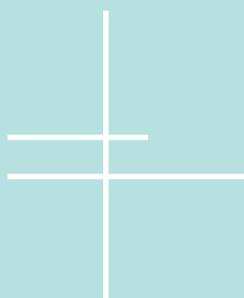
- D Theatre utilisation target of 90%.
- D Theatre utilisation of >100% in less than 10% sessions.
- D Theatre utilisation of <80% in less than 10% sessions.
- D Start time within 15 mins of planned in 100% sessions.

**Suggested data to be collected**

- D Start and finish times of cases and session.
- D Patient cancellations with reasons: patient, surgical, anaesthetic, equipment.
- D Session cancellations with reasons: staffing availability surgical/anaesthetic/nursing, bed availability or equipment.
- D Training cases/sessions.

**Common reasons for failure to meet standard**

- D Inappropriate number cases booked for a theatre session.
- D Cancellation on day of surgery: patient, surgical or anaesthetic.
- D Staffing unavailability.
- D Equipment unavailability.
- D Training issues.



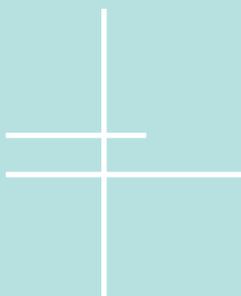
## CPD and Curriculum mapping

CPD matrix codes: I102, I105

Training curriculum: Annex E page E-9, E-10

## References

- 1 Operating theatres. Review of national findings. *Audit Commission Acute Hospital Portfolio* 2003 (<http://www.audit-commission.gov.uk/nationalstudies/health/other/Pages/operatingtheatres.aspx>).
- 2 Theatre Efficiency Safety, quality of care and optimal use of resources. *AAGBI*, August 2003.
- 3 The Productive Operating Theatre Programme. *NHS Institute for Innovation and Improvement*, 2011 ([http://www.institute.nhs.uk/quality\\_and\\_value/productivity\\_series/the\\_productive\\_operating\\_theatre.html](http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_operating_theatre.html)).



## 5-5

## 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.<sup>1,2,3</sup> An assessment of the patient's readiness for discharge is essential and following this, discharge by nursing staff is acceptable.<sup>4,5</sup> Criteria for discharge may vary depending on the procedure and anaesthetic technique used.<sup>5</sup> All patients should receive written information. This should be procedure specific highlighting the expected outcome of surgery, possible complications and a direct dial telephone number for patients seeking support/advice.<sup>6,7</sup>

**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 who agree that their pain was at an acceptable level of control for their own 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 % patients who are satisfied with the arrangements for discharge.
- 7 % patients in whom there is evidence that the discharge home was not satisfactory. This may include use of the contact telephone number for advice or instructions that could have been given prior to discharge, early contact with a community health professional, or readmission.

**Proposed standard or target for best practice**

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

**Suggested data to be collected**

Data collection as above from the discharge checklist and by telephoning the patients at home 24 hours 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.

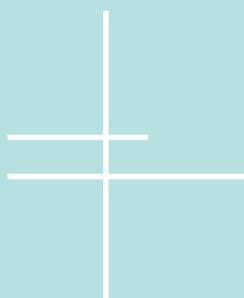
**Common reasons for failure to meet standard**

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

**CPD and Curriculum mapping**

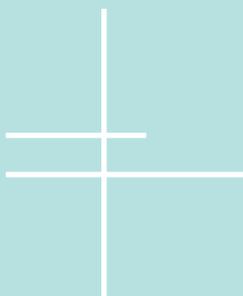
CPD matrix codes: ID01, ID02, I105, 2G04, 2E01, 3A06

Training curriculum: Annex B page B-22–24, B43–44, Annex C page C-20–21, Annex E page E-26–27



## References

- 1 Kortilla K. Recovery from outpatient anaesthesia. *Anaesthesia* 1995;**50**(Suppl):22–28.
- 2 Guidance on the provision of anaesthesia services for day surgery. RCoA, London 2009 (<http://www.rcoa.ac.uk/node/764>).
- 3 International Association of Ambulatory Surgery Recommendations. Discharge criteria (<http://www.iaas-med.com/index.php/recommendations/discharge-criteria>).
- 4 Cahill H, Jackson I. Day surgery: principles and nursing practice. *Bailliere Tindall* 1997, pp 182–191.
- 5 Beesley J, Pirie S. National Association of Theatre Nurses standards and recommendations for safe peri-operative practice. *NATN* 2004. Care of the patient in a day care setting, pp 223.
- 6 Nurse Led Discharge. *British Association of Day Surgery*, London May 2009.
- 7 Marshall S and Chung F. Discharge criteria and complications after ambulatory surgery. *Anaesth Analg* 1999;**88**:508–517.



## 5.6

## 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 best practice tariffs for some day surgery procedures day cases which are admitted may receive a reduced tariff payment.

High unplanned admission rates may reflect sub-optimal practice in a variety of areas, evaluation of this will highlight areas for development.

Some patients may be admitted unnecessarily. Post-admission follow up of these patients may inform more robust discharge criteria and increase confidence in nurse-led discharge.

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 peri-operative management.<sup>1,2</sup> Admission and readmission rates<sup>3</sup> should be regularly evaluated both globally and for individual procedures and efforts made to take steps to improve these where appropriate. Senior anaesthetic support to the day surgery ward and early intervention will avoid many unplanned admissions.<sup>1</sup> Patients admitted overnight should be evaluated the following day to ascertain whether the admission was necessary.

**Suggested indicators**

- D Existence of defined medical and social day surgery exclusion criteria.
- D Protocols for management of anaesthesia, analgesia and anti-emesis.
- D Admission rates and reasons globally and by individual procedure.
- D Evidence that admission rates are regularly evaluated.
- D Rates of readmission within 48 hours of discharge (for problem linked with original procedure).

**Proposed standard or target for best practice**

- D Existence of agreed protocols as above.
- D 100% of patients should meet agreed criteria.
- D There are no standards for unexpected admission, except in urology where the Royal College of Surgeons has suggested readmissions should be < 3%.<sup>4</sup> Targets should be set locally and continually refined. For consideration:
  - ◆ < 2% unplanned admission rate
  - ◆ < 0.5% readmission after discharge.

**Suggested data to be collected**

- D Evidence of protocols in place for selection criteria/anaesthesia/seniority of medical staff/discharge criteria.
- D Assessment of patient suitability against protocols.
- D Assessment of clinical practice against protocols.
- D Admission rates, reasons, clinical outcome; opportunities for improvement.
- D Readmission – emergency admission data linked to previous surgical episode.

**Common reasons for failure to meet standard**

- D Unplanned admission rates are not routinely monitored and hence problem areas remain undetected.
- D No protocol, or protocols not applied – unsuitable patients, procedures, medical/nursing practice.
- D Skill and experience of surgeon and anaesthetist.
- D Poor scheduling resulting in complex patients being operated upon in the afternoon with insufficient time for recovery.
- D Lack of dedicated day surgery unit and staff, day cases using in-patient theatres or wards.<sup>4</sup>

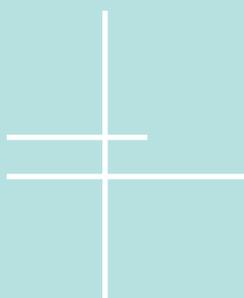
## CPD and Curriculum mapping

CPD matrix codes: ID02, 3A06

Training curriculum: Annex B (DS\_BK\_06), Annex C (DS\_IK\_03), Annex E (DS\_AK\_01)

## References

- 1 AAGBI and BADS. Guidelines on Day Case and Short Stay Surgery. *Anaesthesia* 2011;**66**:417–434.
- 2 Pre-operative assessment and patient preparation — the role of the anaesthetist 2. AAGBI, London 2010 (<http://www.aagbi.org/sites/default/files/preop2010.pdf>).
- 3 Marshall S and Chung F. Discharge criteria and complications after ambulatory surgery. *Anaesth Analg* 1999;**88**:508–517.
- 4 Crew JP et al. Is day case surgery in urology associated with high admission rates? *Ann Roy Coll Surg Engl* 1997;**79**(6):416–419.



## 5.7 Anaesthetic patient reported outcomes in day surgery

Dr M Skues

### Why do this audit?

Patient satisfaction with both the process and outcomes of anaesthetic care is an increasingly important focus for quality assurance. Patient opinion about their clinician as part of multi-source feedback is regarded as an essential component of the revalidation process, yet the development of specific, robust, discrete and attributable outcome measures for anaesthesia can be difficult. The suggested indicators could also be combined with patient derived opinion and satisfaction with perceived quality of care.<sup>1</sup>

Day surgery provides an ideal environment for such a review, as collection of patient-focused data can be facilitated within the course of one working day. Use of this audit can provide confirmation of quality of care provided by departments of anaesthesia within the day surgery pathway, as well as data of potential value for individual anaesthetists to inform their appraisal and revalidation portfolios.

### Best practice: research evidence or authoritative opinion

Guidelines for best practice within the various components of the day surgery pathway have been disseminated by the Royal College of Anaesthetists,<sup>2,5,6</sup> the Association of Anaesthetists of Great Britain and Ireland,<sup>3</sup> the NHS Modernisation Agency<sup>4</sup> and the British Association of Day Surgery.<sup>3,7</sup>

### Suggested indicators

Patient confirmation of:

- D Previous pre-operative assessment as either a face to face or telephone consultation before the day of surgery.
- D Receipt of printed information about anaesthesia and post-operative pain relief.
- D Pre-operative review by an anaesthetist on the day of surgery.
- D Incidence of severe pain or post-operative nausea and vomiting in first stage recovery and their management.
- D Success of regional anaesthesia (if employed for the patient).
- D Post-operative prescription of appropriate analgesia and anti-emetics.
- D Post-operative review by the anaesthetist on the day of surgery.

### Proposed standard or target for best practice

- D 'All (100%) patients undergoing operations suitable for day surgery should attend pre-operative assessment.'<sup>4</sup>
- D 'All (100%) patients undergoing elective procedures should be provided with easily understood information covering anaesthesia and post-operative pain relief before admission to hospital.'<sup>5</sup>
- D 'Before undergoing an operation that requires general or regional anaesthesia provided by an anaesthetist all (100%) patients must be met by an anaesthetist, ideally the individual involved with care.'<sup>5</sup>
- D 'All (100%) patients should receive effective control of pain and post-operative nausea and vomiting'.<sup>6</sup>
- D While post-operative review by the anaesthetist is not essential in a day surgery unit where nurse-led discharge has been implemented,<sup>7</sup> the practice should be encouraged, particularly after the use of regional anaesthesia or chronic pain interventional lists.

### Suggested data to be collected

- D Information collected by patient questionnaire immediately prior to discharge, using the criteria cited above.

### Common reasons for failure to meet standard

- D Inadequate provision of pre-operative assessment facilities or late booking and changes to operating lists precluding timely appointments.
- D Insufficient provision of printed information related to anaesthetic care.
- D Perceived inadequate time to review patients pre-operatively.
- D Absence of agreed protocols/guidelines for management of post-operative pain and emesis in the day surgery environment.

## CPD and Curriculum mapping

CPD matrix codes: ID02, 2A03, 2E01

Training curriculum: Annex B page B-43 and B-44

## References

- 1 Chanthong P, Abrishami A, Wong J, Herrera F, Chung F. Systematic Review of Questionnaires Measuring Patient Satisfaction in Ambulatory Anesthesia. *Anesthesiology* 2009;**110**:1061–1067.
- 2 Guidance on the provision of anaesthesia services for day surgery. RCoA, London 2009 (<http://www.rcoa.ac.uk/node/764>).
- 3 Verma R et al. Day case and short stay surgery: 2. *Anaesthesia* 2011;**66**:417–434 (<http://www.aagbi.org/sites/default/files/Day%20Case%20for%20web.pdf>).
- 4 National Good Practice Guidance on Pre-operative Assessment for Day Surgery 2002. NHS Modernisation Agency.
- 5 Guidance on the provision of anaesthesia services for pre-operative care. RCoA, London 2009 (<http://www.rcoa.ac.uk/node/708>).
- 6 Guidance on the provision of anaesthesia services for post-operative care. RCoA, London 2009 (<http://www.rcoa.ac.uk/node/710>).
- 7 Nurse Led Discharge. *British Association of Day Surgery*, London May 2009.

