



Patients' perceptions of day surgery: A literature review

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Abstract

Medical and pharmacological advances in surgery have contributed to the current and continued growth of day surgery. As the majority of adult UK elective surgery now takes place within day surgery facilities, these changes will inevitably have an impact upon nursing intervention. Past nursing practices may have to undergo a period of redevelopment in order to meet these changes and the logical first step towards any innovative change must involve acquiring the views of patients. The main themes to emerge related to nursing practice, information provision, experiences within day surgery and recovery at home. The overwhelming principle challenge was that of information provision followed closely by postoperative pain management. © 1999 Elsevier Science B.V. All rights reserved.

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1. Day surgery growth

The amount of day surgery has increased over the last 10 years (Table 1) and will continue to do so both in absolute terms and as a proportion of the total surgical workload [1–5]. Day case surgery has been defined as 'a patient who is admitted for investigation or operation on a planned non-resident basis and who

nonetheless requires facilities for recovery' [6].

The Department of Health Performance Guide [7] in which the average national performance figures for three common day surgery procedures are highlighted, clearly demonstrates the impact day surgery is having upon elective UK surgery (Table 2). Its growth has occurred mainly as a result of medical advances and central Government initiatives [8]. The NHS study [9] 'Day Surgery: Report by the Day Surgery Task Force' states that 50% of all elective surgery should be undertaken on a day surgery basis by 1997/98 with some surgical specialities being able to achieve 80% by the millennium. The future growth of day surgery will depend in part, however, on public acceptance [10] and in order to gauge the public's view of day surgery their opinion must be sought. Medical changes in the way patients are treated surgically is inevitably having a considerable impact upon surgical nursing practice, i.e. involving the development of pre-assessment clinics, information provision, same-day discharge and recovery at home. The differences between ambulatory surgical nursing and in-patient surgical nursing may be growing [11,12]. As a result, the data provided from in-patient studies concerning the nursing management

Table 1

Day case surgery as a percentage of all elective surgical admissions in the UK

Date	Day cases (%)
1989/90	34
1990/91	37
1991/92	41
1992/93	45.5
1983/94	48
1994/95	52

Reference: [5].

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Table 2
Department of health performance guide (league tables)

	Inguinal hernia repair	Cataract extraction	Laparoscopic sterilisation
% Of total numbers of UK operations undertaken as day surgery	37	56	80

Reference: [7].

of patients may no longer be applicable to the majority of elective, adult, general surgery patients. Studies which focus specifically upon patients experience of limited hospital stay and comparatively less contact with hospital staff as the norm may increasingly yield information more pertinent to today's surgical health-care system [13,14,10].

2. The patients' perspective

A review of the literature on patients views of day surgery was undertaken utilising a database search which employed Medline, CINAHL, (cumulative index to nursing and allied health literature) and a cross-reference search. Key word combinations were day surgery and satisfaction, ambulatory surgery and satisfaction, anxiety and day surgery and anxiety and ambulatory surgery. The earliest study was from 1978, 12 were from the 1980s and 54 (81% of the total) from the 1990s. The majority were undertaken in America, England, Europe and Australia. A total of 67 studies were identified, both large and small, all of which were utilised as the number of full research studies within day surgery is limited. Furthermore, a systematic review of the literature concerning patients' experiences of day surgery has not been previously undertaken. Studies which merely asked 'were you satisfied with day surgery' or 'what level of pain did you experience' were obviously far too brief and omitted. The only criterion for inclusion was that the data collected was specifically from elective, adult day surgery patients undergoing general, local or regional anaesthesia and was concerned with the patients' self-reported experiences. From the review, four main themes emerged and these relate to: (i) nursing practice; (ii) information provision; (iii) patients' experience within day surgery; and (iv) recovery at home.

2.1. Nursing practice

The need for pre-assessment clinics to help adequately assess patients' fitness for surgery, provide instructions regarding their care and recovery at home and increase the nurses patient contact time to help allay fears, was a strong theme. Implicit within this theme was the provision of information which will be

considered separately as the nursing practice aspect also concerned wider issues, i.e. preoperative instructions, pre-operative anxiety management, patients expectations and discharge.

An audit by Bottrill [15] revealed that pre-assessment clinics were beneficial as nurses had more time to explain treatment to patients which in turn led to a reduction in the junior doctors workload, although the audit only gained a 37% response rate and only included gynaecological patients. In a large study by Guilbert and Roter [16] concerning coping at home after surgery, the most important determinant of satisfaction was patient preparation, i.e. effective communication and instruction. In a study specifically concerned with teaching in day surgery, Brumfield et al. [17] interviewed both patients and nurses about information provision. Patients preferred teaching to take place prior to admission which currently does not occur in all day surgery facilities. The study focused upon patients undergoing laparoscopic surgery, some of which were undertaken for diagnostic purposes, i.e. investigating fertility problems, and this may have influenced the patients informational requirements. In a survey by Harju [18], data was collected using a small questionnaire 3 months after surgery. It revealed that 74% of patients were satisfied with day surgery which was attributed, in part, to good patient selection and adequate pre-operative teaching as part of the pre-assessment visit. Kleinbeck and Hoffart [19] revealed that patients felt quite vulnerable when going home and were unsure about what activities they could perform around the house as clear instructions pre-operatively had not been provided. This led to the trial and error learning of every day activities around the home. Within this American study the literal meaning of day surgery may have been utilised as it states that 'we selected adult patients who were scheduled for elective laparoscopic cholecystectomy procedures and were to be discharged within 23 h after surgery' (pp. 394–395). This leads one to assume that the patients may have spent up to 20 h in the day surgery facility which would not be currently appropriate in most UK facilities. The effects of day surgery facilities without preassessment clinics were highlighted by Rudkin et al. [20] who examined the differences between dedicated day surgery facilities, i.e. own ward and theatre, and mixed facilities, i.e. no separate ward or theatre facilities in eight

Australasian day surgery centres. They concluded that information provision, waiting time and general satisfaction within dedicated units all evaluated better than the mixed in-patient facilities which has obvious implications for future building and resource planning programmes.

Contact prior to the day of surgery has also been seen to help reduce anxiety. In a survey which examined satisfaction with anaesthesia Gupta et al. [21] discovered that 50% of patients would have preferred pre-medication to help allay their fears. It recommended that greater emphasis be placed upon interventions designed to help reduce anxiety in the pre-operative stages. This may be necessary irrespective of the type of anaesthetic used, i.e. local, general or regional. Mealy et al. [22] recommended that a β -blocker (propranolol 10 mg) be routinely given to all patients to help reduce anxiety. A further three studies also suggested premedication to help allay fears and relieve anxiety [21,23,24]. Novice patients, patients with previous unpleasant experiences, female patients and patients undergoing oral surgery all had increased anxiety scores in a study by Mackenzie [24]. It was recommended that, once identified, anxious patients could be given reassurance and anxiolytic medication. Male [23] and Wicklin and Forster [25] also concluded that female patients and patients undergoing local anaesthesia were more anxious, although this data was gained immediately prior to anaesthesia. Nkyekyer [26] revealed that 60% of patients witnessed the care of an unconscious patient while in the day surgery facility and of these, 46% were made more anxious.

Four studies have suggested that general anaesthesia causes much anxiety for patients [23,27–29], whereas others have suggested that patients undergoing local anaesthesia are even more anxious [30] and some more dissatisfied [31]. Furthermore, it was established by Nyamathi and Kashiwabara [32] that the pre-operative cognitive ability of all patients on the day of surgery was reduced. To establish this, the subjects were asked to complete a self-rating of their anxiety and a 100-item critical thinking test immediately prior to a general anaesthetic. A study by Domar et al. [33] examining methods of anxiety reduction highlighted the benefits of contact before surgery for instruction purposes as patients on a programme of relaxation reported being less anxious in the days prior to surgery. The experimental group, however, received more attention than the control group which could therefore have influenced the data. Moreover, the operations were not simple as all the patients involved were undergoing surgery for skin cancer although it does demonstrate that contact on a number of occasions in the pre-operative stages can have a positive effect upon anxiety levels. Markland and Hardy [34] also had positive results when investigating relaxation prior to surgery. In this study the

control group received 'routine' ward care which is not necessarily a reliable or measurable comparison [35].

Gaberson [36] examined the possible benefits of distraction in an effort to reduce anxiety as part of the pre-operative preparation process. Distraction via audio-tape was carried out following admission and lasted for 20 min. No significant reduction in anxiety was established although a longer programme of distraction commencing a number of weeks prior to surgery may have had a greater impact. Augustin and Hains [37] achieved significant results using a choice of audio-taped music albeit on one physiological measure. In a study by Gamotis et al. [11] in which in-patient and day-patient satisfaction were compared, it was revealed that day-patients were more satisfied, in part, because their interaction with staff was more structured and organised, i.e. in pre-assessment clinic and on the day of surgery. However, the female in-patients were more satisfied with the relationship established with the nurses indicating that the comparatively shorter time spent in day surgery did not allow time for this type of bond to be established. Jamison et al. [38] specifically examined the psychological factors believed to influence recovery and concluded that patients who were more anxious pre-operatively were prone to a greater number of complications following surgery. Patients who had a greater number of negative feelings about their recovery also experienced a slower recovery.

The mere physical presence of the nurse was seen to have a positive effect upon anxiety management. Parsons et al. [39] conducted a study to ascertain which behaviours were deemed as caring by patients. Various categories emerged but the top three caring behaviours were reassuring presence of the nurse, verbal reassurance and attention to physical comfort. Therefore, the nurse just being in close proximity to the patient while he/she was in the day surgery facility and expressing concern was viewed as very helpful during periods of increased anxiety. Cozzarelli [40] concluded that helping a patient to increase their feelings of self-efficacy (perceived ability to perform a task well or cope well with a procedure) by providing positive feedback was also an aspect of the nurses therapeutic role. The patients in this study were undergoing day surgery for the termination of pregnancy which may carry a high emotive value and may have accounted, in part, for the reduced number of subjects (38%) who completed all three stages of the study. Vogelsang [41] further highlighted the importance of the therapeutic role of the nurse as it was established that continued contact with one nurse, i.e. from the preassessment clinic through to discharge on the day of surgery, improved satisfaction with care and led to an earlier discharge. Icenhour [42] established that some patients felt rushed and unable to gather all relevant instructions during their admission. Having relatives present on the day of surgery to assist

with information gathering also highlighted their therapeutic role.

Pre-assessment was also viewed as an essential period in which recovery from surgery at home can be discussed (Section 2.4). Pain was identified as a considerable problem following day surgery in a study by Firth [43] where patients had expected to have some pain but had not purchased any analgesia prior to admission. This was either because they had expected the hospital to provide analgesia or they had not been adequately instructed prior to admission. To improve the problem of post-operative pain management it was suggested by Lewin and Razis [44] and Marquardt and Razis [45] that pre-packed analgesia packs with relevant, accompanying information be provided. These packs would vary according to the operation type and may help to establish a more effective programme of pain management. This may involve the nursing staff establishing which pack to administer, explaining to the patient the accompanying information and possibly, in some instances, securing payment. Thatcher [46] in a qualitative study established that pain on discharge was expected but when the recommended or prescribed analgesia did not bring relief, patients found it difficult to cope. One patient was required to pay for the analgesia prescribed and therefore refused the medication.

Discharge from a day surgery facility is largely based on medical criteria. Stephenson [47] in a small study, which is a little vague in parts, established a discharge guide. It was discovered that no patient was fully alert after 30 min and that 57% experienced drowsiness within the first 24 h. Eight studies (Section 2.4) also recommend a telephone helpline be established following discharge to routinely contact patients within the first few days at home. Furthermore, in a telephone follow-up survey conducted by Hawkshaw [48] to evaluate satisfaction with care, one of the unforeseen benefits resulting from this method of data collection was that the patients viewed the telephone interview as a valuable part of their care and a chance to ask questions.

2.2. *Information provision*

The largest theme highlighted in 30 studies (45% of total) relates to information difficulties. More specifically, the lack of information provision, the differing levels of information possibly required, the mode of provision and its timing. Firstly, a comprehensive study by Pollock and Trendholm [49], for 'which'—the independent consumer guide magazine revealed that information provision was a major issue as 'it was clear from our survey that people who were given the least information were the most dissatisfied with day surgery' (p. 16). The Royal College of Surgeons and East An-

glian Regional Health Authority [10] also conducted a comprehensive and highly informative study in which data was collected both on a regional and district basis, incorporated 10 day surgery units, 30 consultant surgeons and 1434 patients. Patients expressed many concerns regarding their forthcoming surgery, the main one being information provision. The study went on to say that although 75% of the patients were satisfied with the care and information they received 'this overall appraisal conceals significant levels of dissatisfaction in certain areas...' (p. 2).

In a qualitative study by Otte [14] subjects preferred the convenience of day surgery as it was less disruptive to their lifestyle although they experienced major problems of communication. All the patients stated that they were unprepared in terms of informational and educational support for their surgery. However, the patients in this study all underwent surgery on a mixed ward facility which has been demonstrated to be less efficient than dedicated facilities [20]. Kempe and Gelazis [50] studied the effects of pre-operative verbal and written information on anxiety and concluded that greater psychological preparation, i.e. an increased amount of information, resulted in a less anxious patient. No account was given to the effect of increased attention provided for the subjects in the experimental group or that they were given a systematic programme of information. A study which explored patients experience of laparoscopic surgery was undertaken by Nykekyer [26] and 29% of the patients were unhappy with the level of information they received. Furthermore, this figure could be higher as this data was collected 2 weeks after surgery in the hospital out-patient department. Asking patients to comment about their care whilst still undergoing medical treatment has been seen to give rise to inaccurate responses [51] and in an attempt to circumvent this problem, some studies have utilised postal questionnaires following discharge.

Sigurdardottir [52] in a postal survey, compared satisfaction with care between 2 day surgery facilities and the main areas of concern stemmed from the lack of adequate information as 'the patients were least satisfied with items related to the educational sub-scale as they seldom received any booklets or pamphlets relating to the surgery' (p. 73). Again, however, one of the facilities within this study was a mixed facility. Buttery et al. [53], although only using a short questionnaire, established that most patients were satisfied with day surgery. The main criticisms centred around the long pre-operative waiting period, the lack of post-operative privacy and the provision of insufficient information. Willis et al. [54] conducted a postal questionnaire and discovered that there were significant correlations between receiving written information and the level of satisfaction, and receiving an explanation and recommending day surgery to a friend. MacAndie and Bing-

ham [55] examined patient satisfaction and general practitioner involvement in care. A total of 20% stated that their discharge information was excellent and 50% good, while the remainder were dissatisfied. King [56] revealed from the subjects who replied (44% response rate) that 30% received no written information concerning their care although 97% were happy with their discharge information. A 44% response rate, although good for a postal questionnaire, may also hide the true level of satisfaction, i.e. are those who did not reply too dissatisfied/satisfied to do so?

Five studies have highlighted an inherent dilemma with information provision in that too much and also too little can cause an increase in anxiety. Oberle et al. [57] stated that 'although 25% of patients indicated that they had received little or no information about their surgery and post-operative course, some of them were satisfied with that; they indicated that they simply preferred not to have any details about their upcoming surgery, because the more they knew, the more frightened they would become' (p. 1024). In a study of patients undergoing surgery and general anaesthesia by Goldmann et al. [58] the effects of hypnosis and information provision on anxiety were examined. The question most frequently asked of the anaesthetist was whether induction of anaesthesia would be by mask or needle and the most informative aspect for the majority of patients was to be told the length of anaesthesia. Only a mean, significant difference in anxiety scores was achieved for patients who had undergone 3 min of hypnosis although it was established that 'The provision of information does not have a uniformly positive effect. Patients may either wish to be informed about the details of their operation, remain uninformed, or a mixture of both' [58]. In a study by Mitchell [29] female patients scheduled for day surgery were interviewed 1–2 h prior to general anaesthesia. The aim of the study was to establish a possible link between individual information requirements and locus of control. No significant link was gained although again the need for differing levels of information was established as 41% would have preferred a detailed booklet and 53% a simple information booklet. However, the data was collected from gynaecological patients only and at a very anxious period. A patient satisfaction survey by De Jesus et al. [59] revealed dissatisfaction with the information provision because of its lack of adaptation to home recovery. '... the single most common suggestion from surveyed patients on how to improve same day surgery services is to cater for possible complications through provision of clear and specific information' (p. 171) and it was again established that not all patients required the same level of information. An extensive study by Caldwell [60] concluded that patients may have differing informational requirements as those who had a greater need for information also had lower

levels of pre-operative anxiety. A total of 43% of the patients within this study were uncertain about a diagnosis of malignancy. It concludes that identifying the patients who require more information could be very difficult.

A further four studies have demonstrated the need for patients not only to receive verbal and written information but also the chance to view, or take home to view, a video-tape concerning their surgical procedure. Wicklin and Forster [25] conducted a study to establish whether modelling of behaviours from a video-tape presentation prior to surgery was of greater benefit to patients than just the provision of information. The only conclusion was that females reported a greater level of pre-operative anxiety than males. The number of viewings and the duration of the presentation were not given. Lisko [61] conducted a small pilot study where gynaecological patients viewed a short video-tape presentation. The purpose was to encourage greater autonomy although no significant results were established. Baskerville et al. [62] over a 9 month period, provided patients with an audio-tape concerning their operation. The information was well received and highlighted the need for information prior to the day of surgery. Three further studies have highlighted the problem of the timing of information provision. Brumfield et al. [17] established that patients preferred teaching to take place prior to admission. In a study by Oberle et al. [57] a number of patients were dissatisfied with the timing of information provision as it did not occur until the morning of surgery. Mitchell [29] further revealed that 48% of patients would have preferred to receive some written information at least a few days prior to their operation.

Early discharge is preferred by patients although only when provided with adequate information [14]. In a study by Kleinbeck and Hoffart [19], the patients were unsure about what activities they could perform around the house and would have preferred more information concerning recovery at home, i.e. what activities can be undertaken and when. Donoghue et al. [63] reported patient satisfaction with the information they received although it did not cover possible problems at home. Guilbert and Roter [16] and Hawkshaw [48] stated that patients coped well at home when discharge information provision was good.

2.3. Patients experiences within day surgery

A number of issues relate to patients experiences of day surgery. They mainly concern their expectations, waiting following admission, lack of privacy, preference for an overnight stay and anxiety. A large number of studies highlighted the public's general satisfaction with, and preference for day surgery [18,21,38,49,52,53,64–67]. However, some aspects within day surgery were not

always expected. In a survey by MacAndie and Bingham [55] it was revealed that a number of patients thought day surgery was minor surgery while others were surprised at having to walk to theatre. Birch et al. [68] surveyed patients attitudes towards walk-in surgery and found that 98% expressed satisfaction for this approach although they were all still attending the hospital out-patients department at the time of data collection. In a study examining participation in decision making Avis [69] revealed that patients preferred to allow the doctors and nurses to make their choices as they viewed them as the experts but they also realised that this limited their involvement in decision making.

Following admission, seven studies reported that waiting for the operation was a problem as it led to an increase in anxiety. Pollock and Trendholm [49] reported 20% had to wait > 3 h for their operation and Read [70], Otte [14], Rudkin et al. [20], Buttery et al. [53] and Ghosh and Sallam [67], all reported that anxiety was increased by the period of waiting following admission. Nkyekyer [26] and O'Connor et al. [65] reported that 34 and 11% of patients, respectively, found the wait prior to surgery too long. As a consequence, both Ghosh and Sallam [67] and Otte [14] recommended staggered admission times. Privacy within the day surgery facility was also a recurrent problem reported by Buttery et al. [53], Ghosh and Sallam [67] and the Royal College of Surgeons and East Anglian Regional Health Authority [10] all recommended improvements in this area.

Four studies revealed that some patients were not happy to go home following their surgery and would have preferred an overnight stay. In a comparatively older study by [71] 54% thought their stay was too short as opposed to 21% of the in-patients. [72] revealed that 74% would have preferred an overnight stay although this data was collected 3–6 months after surgery. In a study by [73], 8% would have preferred an overnight stay and [65] concluded that male patients may prefer day surgery more than females as 16% of females preferred an overnight stay. This figure increased further in a study by [26] as 52% of female patients would have preferred an overnight stay although these patients had all undergone intravenous sedation with local anaesthesia.

2.4. Recovery at home

The final theme relates to the first few days and weeks at home and concerns pain management, recovery and help required, and community health involvement. Firstly, [67] reported that one of the main sources of dissatisfaction in the post-operative period was inadequate pain relief and in studies by Clyne and Jamieson [64] and Birch and Miller [68], 50% of patients experienced pain while at home. [43], utilising a short ques-

tionnaire, discovered that 25% of the subjects were awake on their first post-operative night with pain and 31% of all the subjects received only partial or no relief from their pain using the prescribed drugs. [46] also reported that the recommended or prescribed analgesia did not always bring relief. [13] reported that the severity and duration of pain was not expected by most female patients and [74] further reported that female patients undergoing gynaecological surgery experienced a great deal of pain. Both Lewin and Razis [44] and Marquardt and Razis [45] concluded that postoperative pain management was a problem and recommended pre-packed analgesia with relevant information. [66] established that 96% of patients were satisfied with their post-operative pain management although in this study a community liaison sister visited during the immediate post-operative period for wound management and to give advice.

Once discharged from the hospital [21] discovered that some patients drove home (4%), many went home unaccompanied by an adult, 25% were alone during the first 24 h and 8% alone during the first 24 h without an adult to look after the children. [68] also found that 13% of patients drove their car the same day and the majority returned home alone. [75] utilising a short questionnaire reported that on the first night of discharge, 7% drove their car, 42.7% reported feeling drowsy and 38.8% had a headache; 'there was a wide distribution in the time to recover to full normal daily activity, ranging from the day of operation in four patients, 1 to 2 days in 45 patients, 3–5 days in 33 patients and ≥ 6 days in 21 patients' (p. 29). [76] revealed the main post-operative problems were muscle aches, sore throat and drowsiness and [64] reported that 52% of patients stayed off work for > 1 week. Recovery times may differ widely as Ratcliffe et al. [73] and Wilkinson et al. [77] established that almost three-quarters and 84%, respectively, still had problems 3 days after their operation, whereas [47] reported almost half were active on the second day and [76] reported that 32% resumed normal activities the next day with a further 62% after 3 days.

[78] conducted one of the few studies which also asked the carers to complete a questionnaire concerning their experiences of caring for a relative following day surgery. More than 30% of the patients required help with the activities of daily living in the first 7 days although 'helpers tended to overestimate the patients need for assistance' (p. 1006). [65] reported that 62% of patients required a carer for ≤ 1 day and 20% for 1–2 days. Female patients required more assistance than males with 3% paying someone to help with childcare, housework, etc. [10] revealed that more than one third of patients required a great deal of support from helpers at home, 20% of whom had to take time off work. [54] established that 21% of patients required

help from carers, 10% of whom had to take an average of 3 days off work with 7% losing earnings. To enable both patients and their carers to gain much needed advice following discharge, seven studies recommended the use of a telephone helpline [19,44,50,54,55,59,79]. In a study by [13] which was, in part, conducted over the telephone, it states that 'there seemed to be a therapeutic factor embedded within the interview process for some women' (p.176).

The level of community health involvement was reported in 11 studies and mainly concerned visits to the general practitioner or by the district nurse. In a survey utilising two simple questions by [80], 93% of the patients, although having undergone a moderate surgical procedure and general anaesthesia, did not seek any community-based help in the first three post-operative days. [68] found that 19% had to contact their general practitioner within the first 2 weeks and [56] revealed that only 5% of patients required help in the first 48 h. [79] established that 19% of patients had to visit their general practitioner at least once regarding pain management or wound problems. An Australian study by [81] revealed that district nurses were utilised within the post-operative period for $\approx 2-3$ days. A total of 21% of patients contacted their general practitioner within the first 2 weeks regarding pain management or wound care. [72] found that day surgery patients required significantly more medical attention following their discharge. Likewise, in studies by the Royal College of Surgeons and East Anglian Regional Health Authority [10] and Willis et al. [54] almost half of the patients required help from one community health service. As ever more complex surgical procedures are undertaken within day surgery and the amount of day surgery increases, the workload within the community may also increase although cost savings may still be achieved as less time is spent in hospital [81].

3. Conclusions

Although satisfaction within day surgery is high, four main themes emerge of which information provision and pain management at home present the greatest challenges. Within nursing practice there is a strong requirement for the establishment of pre-assessment clinics to increase contact time with the patients, improve communication and help allay fears. A number of measures attained moderate success in anxiety management, i.e. early contact, relaxation, distraction, therapeutic role of the nurse and positive, encouraging statements. Other practices requiring consideration relate to patient discharge criteria, analgesia dispensing and telephone follow-up calls.

Issues surrounding the provision of information by far present the greatest challenge (improvements recom-

mended by 45% of total) and are implicit within the other themes. A general lack of information is a common element especially within mixed facilities. However, not all patients want the same level of information as some are made more anxious with too much information and vice versa. Information relevant to home recovery, i.e. management of the wound, daily activity level, what to do if, etc. were all frequently cited as being most useful. Video-tape presentations had some success and providing information prior to admission was widely viewed as a positive step.

Patients' experience within day surgery relates to realistic expectations of procedures on the day, level of pain and incapacity following surgery. Much anxiety is generated by the time spent waiting for surgery following admission, the lack of privacy and the prospect of undergoing any type of anaesthesia.

Finally, pain management is a considerable problem during recovery at home, especially for some gynaecological patients. Although carers were happy with their role, more information is required as is time in which to make social arrangements to accommodate their temporary role. There was generally only a small increase in the workload for general practitioners and district nurses although if the number of day surgery patients and procedures is to increase, this may change.

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