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Free papers on quality control in ambulatory surgery — Session 7a

7a1
Permanent quality assurance in ambulant pacemaker implantation

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INTRODUCTION/METHOD: Since 1993, we have been recording at the Wetzikon Hospital our pacemaker implantation in a prospective study. In a first phase, the majority of implantations are made as a rule in an ambulant way (hospitalisation, less then 24 h, one night, telemetry).
RESULTS: Our report is based on 395 pacemaker implantations (140 stationary, 255 ambulant) in the period 1993–1999. Three hundred and twenty two first time implantations, 73 reinterventions had to be made (battery exhaustion, threat of skin penetration).
CONCLUSIONS: The ambulant implantation of a pacemaker system can be achieved in an easy and secure way. Our prospectively collected data allow us to perform a permanent quality assurance.

7a2
Standards for ambulatory units accreditation. The first handbook

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After 12 yr, ambulatory surgery has good acceptation and large involvement in the Spanish hospitals.
Hospitals made self protocols, guides, pathways... and actually it is necessary to acreditate the ambulatory surgery units. The Spanish Ambulatory Surgery Association–ASECMA and the Health National Resources–FIS carried out until the last two years the first spanish accreditation handbook with standards about which. The standards are actually in validation.

7a3
Total quality management in ambulatory surgery in Switzerland

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Since 1995, the Swiss Medical Association and the Swiss Accident Insurance companies have administered a quality assurance program for ambulatory surgery in private operating rooms. This program includes a certification of the facilities of the operating units, a quality assurance evaluation for the surgical procedures as well as the clinical outcomes. A committee manages and reports the results from this TQM-program. Nearly 120 private operating units in Switzerland participate with the insurance companies in this program. In case that a surgical operating room does not meet the standards of the TQM-program, sanctions can be taken. This means that poorly performing operating rooms can be excluded from the contract and furthermore will not receive sufficient payment for the cost of running their infrastructures. In the last 3 yr, none of the surgical facilities has been excluded.

7a4
Quality and accredit: new frontier of day-surgery

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The existence of a day-surgery (DH) in an hospital, appears today as a fundamental organizational model.
As we still considered in the former DH world congress our surgical unit has been able to save, through such a model more than half a billion lire in two years. The aim in that of allocates resources without delay towards more important pathologies such neoplasmas. The autonomous unit is the top among the organizational possibilities of a DH. This autonomy can be reached at different levels such administration, structure and management. We consider the structural level as the most important. The possibility of realizing an organization with managing autonomy would allow developing other activities as quality control and accrediting. From such a point of view, we only need to consider the means that we own and lead then to the target funding our activity on quality. We consider basically three different proceedings: medical record, DH rules and information brochure these are part of quality index as well as the possibility of reaching data and the need of information. What we have above considered is never the less a high expression of administrative and managing capability that could strongly characterize a hospital. The second fundamental level on which we must insist is the accredit, the mean through which we may guarantee quality. As it allows the contemporary evaluation of professional capability, the resources allocation, the reaching of services, the risk and the satisfaction of the patients and of the surgeons.

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Only through a narrow link through accredit, quality, continuous improving programs and scientific severity will be possible to reach good results not only professionally but also clinically and humanly speaking.

7a5

An exploratory study of patients' expectations and experiences of day care surgery in a single NHS trust in the UK

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Literature suggests that little is known about the patients' expectations and experiences of day care surgery (Otte, 1996; Mitchell, 1997; Reid, 1997). Day care surgery will continue to increase in the future. This study's purpose is to provide knowledge to enhance nursing practice. The study had three aims: to identify expectations and experiences of day care surgical patients, to examine factors, which patients liked or disliked about their care, and in light of the findings to explore how nurses can improve practice. Data were collected in two stages: stage 1 involved a purposive sample of adult patients ($n = 152$). Self completed questionnaires were administered on two occasions to three categories of patients (General surgery $n = 48$, orthopaedic surgery $n = 55$, plastic surgery $= 48$); immediately after their first day care appointment before admission and no later than two weeks after surgery. Stage 2 involved semi-structured telephone interviews with a sub-sample of stage 1 patients ($n = 28$), selected to represent both positive and negative experiences. Preliminary findings indicate that the majority of patients found the process of day care surgery efficient but not necessarily effective. Men evaluated their experiences better than women. Methods of patient referral and preparation varied across surgical groups and were found to be influential, when patients reflected on their care experience. Experience of recovery at home appears to influence women more than men when considering day care surgery in the future. Analysis is not complete but suggests that the majority of patients approve of day care surgery. Improvements could be made to processes of referral and preparation of patients, especially, when planning care for women.

7a6

A role for general practitioners in the management of ambulatory surgical patients: facts and wishes. A French survey.

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INTRODUCTION: According to the literature, implication of general practitioners (GPs) is the key point for successful handling of ambulatory surgical patients. The reality does not seem to reflect this assumption. The aims of this postal survey were to collect information on the implication of GPs in the management of ambulatory surgery (AS) and to analyse the role they would like to play.

PATIENTS AND METHODS: A questionnaire including more than 100 items was sent in 1998 to 1709 GPs in southern France (Gard and Hérault states).

RESULTS: Replies were obtained from 388 GPs (22.7%). 81.4% were concerned by ambulatory surgery. *Experience with AS:* 94.0% of GPs followed patients having had ambulatory procedures. 50.2% proposed AS to their patients and referred them to a surgeon. 73.4% were active in the preoperative preparation and 89.6% visited their patients at home after AS. 31.0% have co-ordinated medical and nursing home care. Preoperatively, the main roles of GPs were to give information (75.2%), to adapt chronic treatments (73.4%) and to prescribe intestinal preparation if necessary (34.9%). Postoperatively, GPs visited patients at home on call (97.4%), because they were asked by the surgeon and/or the anaesthesiologist (65.0%) or systematically (33.8%). *Implications wishes from GPs:* GPs wanted to inform their patients on the possibilities, advantages and disadvantages of AS (83.9%), to choose the adequate ambulatory centre (56.0%), to choose surgeon (78.8%), to inform the anaesthesiologist on patient's problems (94.0%) and to participate to preoperative preparation (40.5%). Concerning immediate follow-up, 48.4% wanted a systematic visit, 49.4% only in case of problem and/or on patient's call and 1.6% do not want to play any role in AS, arguing this was the specific responsibility of the surgeon/anaesthesiologist. 62.0% wanted to co-ordinate postoperative home care.

CONCLUSION: GPs are implicated in the whole perioperative period of ambulatory procedures. A majority of them wanted to be responsible for their patients before and immediately after surgery.

7a7

Use of a structured interview technique to obtain patient's perspective on the day surgery experience and identify changes to improve the quality of the service in line with these comments

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Patient satisfaction with all aspects of day surgery is important for high quality care. The most common way of assessing this is by means of a structured questionnaire. While these form a useful audit tool and can be submitted to statistical analysis they have limitations in the range and content of questions and scope for comments. We designed a small prospective study to obtain an in depth descriptive impression of the day case experience from the patients perspective.

The study was undertaken by KB as part of her medical degree and had local ethics committee approval. Patients were recruited in the day unit by giving written consent. An agreed date and time for a telephone interview was made. Interviews were conducted 4–7 days after surgery and were structured to follow the course of the patient's treatment, topics were discussed using 'open-ended' questions.

Of 47 patients recruited 31 completed the telephone interview. This was a qualitative study and results are presented as a series of discussion points. Most patients were generally satisfied with their treatment as a day case. Areas of dissatisfaction included issues of privacy, unrealistic expectations of recovery, attitudes of staff and relatives/carers and the quality of information given. Many of these had not previously been identified or lacked specific detail. A 20-point action plan was produced and is being implemented, audit using a questionnaire designed to target the issues raised is planned. This technique can complement other types of patient satisfaction audit and be used to improve the quality of the day surgery service.

7a8

The use of patient questionnaires and nursing care programmes in quality control at a day surgery unit

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The day surgery unit at the ENT department, Danderyd hospital/Karolinska hospital, Stockholm, Sweden opened in 1996. Since then the degree of surgical complexity of operated patients has increased year by year. The experience of using patient questionnaires and nursing care programmes to maintain and improve nursing care quality will be presented. During the last years, yearly questionnaires have been given to 100 patients. We have produced the questionnaires ourselves, which has the advantage that they can focus on what we believe to be problem areas and stimulate to quality improvement actions. For example, focusing on information issues has led to improvements in the written information and focusing on the patient experience of their condition, when leaving the unit has stimulated improvements regarding prophylactic measures to decrease postoperative nausea and vomiting. Written nursing care programmes have been produced for each surgical procedure performed. These programmes include information on the most common postoperative problems and how to take care of them. The nursing care programmes makes it possible to standardise basic procedures and to analyse and improve these procedures.

7a9

Analysis of the satisfaction level linked to the patient's state of anxiety in day surgery

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INTRODUCTION: For the evaluation of the patient's level of anxiety in DS the following variables have been analysed: hospital facilities, service organization, nursing and medical treatment time, personal updating, information given to the patient, care and/or assistance of discharged patient.

AIM: To determine an optimum model in DS service.

MATERIALS AND METHODS: The study was carried out on a sample of 300 patients operated on in 3 different hospitals (Legnago, Zevio, Nogara) belonging to the same hospital administration ASL 21 Verona with superimposable procedures of acceptance, discharge, surgery and anesthesiology but with different features. The analysis was done through a questionnaire – survey given to the patient in the discharging phase and on the 30th day by external staff to the 3 DS services. In brief: Legnago hospital: intensive, ward with dedicated beds, general operating theatres, nursing staff without ward specific preparation, non dedicated operation nursing staff, non dedicated surgeons, waiting list from 1 to 6 months; Zevio hospital: reconverted reabilitative hospital, ward and operating theatres with dedicated beds, dedicated nursing staff, dedicated surgeons, one month waiting list; Nogara hospital: reconverted district hospital, ward and operating theatres with dedicated beds, dedicated nursing staff, dedicated surgeons, hospital staff with specific operator–patient updating, 4 months pre-arranged waiting list.

RESULTS AND CONCLUSION: In brief the satisfaction level and the state of anxiety are linked to waiting time, assistance time available, information given to the patient and organization in hospitalization phase, while positive results were evaluated concerning the surgical and anesthesiological treatment after the 30th day.