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Abstracts of Session 7b

Free papers on preoperative managament

7b1

Organization of the pre-operative phase programming of patients in an out patient setting

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Our experience shows the need to establish a number of factors that have to be followed a respected:

- an operating grid with schedules specialities
- operating protocols
- selected surgery
- pre-operative anaesthetic visits
- pre-operative nursing visits (the goal being the achievement of a global patient approach).

Planning outpatients for surgery must take place in a dynamic, motivated medical a nursing team. Any modified plannification can cause difficulties for the patient, for example, a:

- special day off, planned at work;
- mother who organized someone to care for her child;
- prolonged absence from work.

To establish an operating out-patient schedule, certain priorities and criteria must be respected:

- age
- known illness
- type of anaesthesia
- patient anxiety
- travelling distance from the patient's home to the center
- mother living with very young children
- planned operating time.

A phone call to contact the patient on the eve of surgery to:

1. confirm the schedules time
2. avoid unnecessary witing time, which diminishes stress
3. manage patient circulation.

CONCLUSION: The planning of out-patient surgery must not be improvised. The patient must remain the center of all activities. Coherence between partners and the respect of plannification are key factors to succeed in ambulatory surgery.
The engagement of each actor is necessary and contributes to the success of a global and individualized management of the patient.

7b2

National booked admissions programme – implementation at King's college hospital, London

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The National Booked Admissions Programme was launched in 1998 as part of the Government's strategy for modernising the NHS. The programme is aimed at making the NHS more accessible and convenient to patients, and in achieving that; using resources more efficiently.
Ministers have said "they wish booking hospital appointments to become as easy as booking travel tickets and hotel reservations in the future".
The Government funded 60 pilot sites to implement 'Booked Admissions' from October 1999 to March 2001 and King's College Hospital was selected. The project has seven broad objectives:

1. Redesign systems so that patient's can get a date for treatment at the time the decision is made.
2. Improve communications between primary and secondary sector.
3. Give patients more choice and certainty about dates for treatment.
4. Simplify and speed up the patient process from referral to treatment.
5. Improve efficiency within the booking system.
6. Improve patient and GP satisfaction.
7. Prevent duplication in the referral to treatment process.

It has been demonstrated, by many pilot Trusts that it is easier to implement 'Booked admissions' for patients requiring day case procedures than it is for patients requiring in-patient admissions, particularly where day procedures/surgery are provided in units which are separate from in-patient beds.
This paper will explain our approach in implementing new systems at King's and discuss benefits and outcomes.

7b3

Dogma or common sense – a review of exclusion criteria for day surgery

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Day surgery has now developed into a front-line clinical service offering surgery to over 60% of all elective surgical procedures. It should no longer be considered as second best and it should no longer be provided in out-dated accommodation and undertaken by clinicians with limited experience. Unless the peri-operative environment is as good as that provided for elective in-patient surgery, it should not be offered at all. This being the case it is time to review the criteria for selecting patients suitable for day surgery.
This paper reviews the historical background to the adoption of clinical and administrative exclusion criteria. It suggests that much of the dogma surrounding the selection of patients is no longer applicable. It emphasises the importance of pre-operative assessment as a

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means of preparing the home environment rather than acting as a barrier to referral for day surgery. It supports the statement made by the President of the British Association of Day Surgery in his statement (BMA Review, August 2000) "General Practitioners and Surgeons have to stop asking themselves whether patients are suitable for treatment as day cases and consider instead what possible reasons there are for subjecting them to in-patient care".

7b4
A safe triaging tool for pre admission

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INTRODUCTION: In January 2000, a triaging process was introduced to the Pre admission Service at St. Vincent's Hospital Melbourne. Instrumental to this process was the design and implementation of a short Health Questionnaire. Most surgical elective patients complete the questionnaire and based on their answers are identified as either requiring a formal preoperative consultation in the designated pre admission clinic, or requiring no preoperative work up other than the Questionnaire prior to being admitted on the day of surgery. At St. Vincent's Hospital, Melbourne 82% of elective surgical patients (including Neurosurgery and Cardiothoracic patients) undergo a *pre admission process*. Of that number currently 36% are triaged as requiring no further assessment and the remainder attend the formal pre admission clinics.
PURPOSE: To assess the accuracy of a Health Questionnaire to identify patients requiring no further preoperative preparation.
METHODS: Study one was a retrospective descriptive study of 104 consecutive patients identified by the Health Questionnaire as requiring no further preoperative preparation. This study provided baseline data on gender, age, and smoking status and unit utilisation.
Study two was a Matched Pairs Cohort study, designed to test whether postoperative outcomes differed between patients triaged as requiring no further preoperative preparation, compared to similar patients who had attended a formal Pre admission Clinic. A random sample of twenty-three patients was used in the comparison.
Twenty-one categories affecting postoperative length of stay were used to capture information relating to post operative outcome of individual patients.
RESULTS: Use of the Health Questionnaire as a triaging tool is an effective and safe method for identifying patients that require no further preoperative preparation.

7b5
Multidisciplinary meetings to optimise patient selection and preparation for day surgery – an audit

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In our institution all patients scheduled for general anaesthetic procedures in the day unit are assessed 2–3 weeks prior to admission by specially trained nurses. The move to managing more complex cases and less fit (ASA 3) patients has presented a challenge to select appropriate patients and optimise their medical condition. A 1 h weekly meeting between the assessment nurses and a Consultant Anaesthetist were set up. The assessment nurses identified patients in whom there were problems that could not be resolved using current guidelines. The hospital notes and results of any investigations were taken to the meeting and the case presented to the Anaesthetist. The care of 103 patients was planned in 12 meetings over a 3 months period.
Care for 50 patients were decided at the time. In 53 cases further actions were taken, including referral to their GP or other specialists, request for investigations etc. The ASA grades of the patients reviewed were 37 ASA 2, 59 ASA 3 and 9 ASA 4. All the ASA 2 and 44 (75%) of ASA 3 patients were considered suitable for management as a day case. Plans for the remaining patients were: seven to have overnight stay on the day unit, 12 scheduled for the procedure as inpatients, five suspended from the waiting list pending medical management and one cancelled. Two-day cases have required admission to inpatient beds, one due to a prolonged reaction to anaesthesia in the other the surgical procedure was much more extensive than anticipated.
This model is an effective way of managing this group of high risk day surgical patients and optimises the use of the Anaesthetic consultants time.It also offers important opportunities for teaching and professional development for nurses in this field.

7b6
Can patients be scheduled for day surgery operation by direct referral letters?

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INTRODUCTION: In a well-functioning day surgery unit it is crucial that patients scheduled for operation have correct diagnosis and operative indication and that they are carefully assessed for anaesthesia fitness. In the Oulu University Hospital all referral letters sent for general surgery are reviewed by surgeons, who decide whether the patient needs the conventional visit to the outpatient department before surgery or is scheduled directly for operation. We wanted to evaluate the appropriateness and patients' experiences of this direct referral-practice.
PATIENTS: 401 randomly selected patients scheduled for day surgery were evaluated. Six patients were rejected due to missing data. Of the remaining 395 patients, 53% were scheduled for operation after a visit to the general surgery outpatient department (conventional patients) and 47% by direct referral letters (direct referral patients).
RESULTS: Five operations were cancelled in the direct referral group and four in the conventional group. The reasons for cancellations in the direct referral group were new injury, pregnancy, skin problem on the planned operation area and back problems.
In the remaining patients, 28 direct referral patients and 13 conventional patients had some problems with regards fitness for anaesthesia.
The diagnosis remained unchanged in 81% of conventional and 89% of direct referral patients. The procedures were carried out as originally planned in 85% of conventional and in 95% of direct referral patients. Procedures were respectively lager in 13% and 4% and smaller in 2% and 1%.
Unplanned admission rate was 8.6% among direct referral and 3.8% among conventional patients. 12% of direct referral patients stated that would have preferred to visit the outpatient surgery department before the operation.
CONCLUSIONS: Direct referral practice is appropriate and is not related to the cancellations of operations, but to some extent increases the unplanned admission rate in the unit. The problems with fitness for anaesthesia, which are not mentioned in the direct referral letter, increases the workload of the anaesthesia personnel, but does not cause cancellation or unplanned admission.

7b7
Preoperative testing procedures for days units

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The preoperative testing procedures for day surgery units are a basic step when considering the use of day surgery facilities in a hospital whether in terms of efficiency, effectiveness of the testing with regard to the clinical conditions of the patients, or in terms of informing the patients about operative procedures and anaesthesia. In this way there is a rational utilisation of resources for the patients (avoiding loss of time) and for the hospital (avoiding useless testing).
The purpose of this paper is to describe the pre-operatives procedures in the Carpi hospital (Modena – Italy) and to describe how the rationalisation of pre-operative testing procedures according to the criteria of the Italian Society of Anaesthesiologists allowed certain benefits for the hospital and for the patients.
In our experience the pre-operative route follow this steps:

1. The surgeon's examination of the patient to decide the necessary operation, whether the day surgery unit was adequate, and if the patient consented
2. The anaesthetist's check, which includes tests of the heart, lungs etc: then the patient fills out a questionnaire of his medical history and, (only in case of need), the patient is sent to take other routine laboratory tests such as blood, X-rays etc.
3. The anaesthetist informs the patient of the anaesthetic to be used in the specific surgical procedure.

The results and effective uses of the ISA (Italian Society of anaesthesiologists) recommendations allowed the following benefits:

1. Using lab-tests only when specifically required in the pre-operative step
2. Reducing unnecessary pre-operative testing procedures which reduced costs that we estimate in about 15 millions lira for X-rays and 15 millions lira for laboratory test.
3. Reducing of time loss for the patient, which we estimate in about 2 h for each patient.

7b8
Routine preoperative testing in ambulatory surgery

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INTRODUCTION: The custom of requesting preoperative examinations is a position very difficult to remove, in our centre.
AIM: Determine the uselessness of requesting preoperative examinations routinely.
MATERIALS AND METHODS: We performed a retrospective study over 500 patients with preoperative testing, randomized, operated in a period of 9 months, with age limits between 1 and 87 yr. The surgeries performed were of different kind, and the anaesthesia's was provided depending on the surgical procedures.
RESULTS: Over 500 patients, only 30 had abnormal results that frequently appeared in ECG, BUN, glucose and hematocrit; and the patients had pathologies diagnosticated that supported them. In all those patients was no necessary to cancel surgery, to change the kind of anaesthesia and there were no complications in the operative room or in the postoperative recovery.
CONCLUSIONS: This works leads the conclusion that preoperative testing in Ambulatory Surgery should be not required routinely. The medical consultant plays a significant role in the evaluation and management of patients before ambulatory surgery, to define the patient's medical conditions by a complete history and physical examination. Testing of asymptomatic healthy patients had not been found to be helpful and is not recommended. The basic idea of decision analysis is to model the options in a medical decision, assign probabilities to alternative actions, assign utilities to the various outcomes and then calculate with decision. All this results in a lot of benefits, mainly, to reduce healthcare costs.

7b9
Flow chart for the pre-operative preparation of the patient in case of ambulatory surgical treatment

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A good stay on a Day Surgery Unit largely depends on the way it was organised on the day itself, but also on the organisation of the pre-operative preparation.
Once the decision for ambulatory surgery has been taken, the patient needs a proper pre-operative check-up and management. In Belgium there is no such thing as a "pre-operative check-up fee" and so these check-ups are carried out in hospitals by physicians or even out of hospitals by the general practitioner. This requires very specific and clear arrangements.
A flow-chart in which all the necessary steps are set out is proposed. If the patient had his pre-operative check-up in the hospital all the test-results finally go to the admission service the day before surgery. The same happens if the patient was seen by his general practitioner for his pre-operative check-ups.
Assessment of the pre-operative check-ups and test results is done on the admission service who gets in touch with the patient if something is wrong.
This system proves to be satisfactory. It assures us that the number of incomplete files on the day of admission is minimal.

7b10
"Words fly, writings apply": From oral convocation to written convocation?

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Why this title? Why should we be concerned about the convocation of ambulatory patients in endoscopy?
These patients have to reconcile the fear of the examination with their familial and professional responsibilities. Hence, the importance of supplying all the necessary information to help them comply with the necessary technical instructions and limit their anxiety of an unknown procedure.
Since the appointments are given by telephone by the nursing staff, the transmission of oral information to the patient is unreliable. On the other hand the disposability of the endoscopist at a desired time schedule could be unknown to the nursing staff. This led to the project I realised at CASA [Cycle d'Approfondissement en Soins Ambulatoires (Continuing Education in Ambulatory Services)] in 1998, in order to improve and optimize the scheduling system. In order to handle the appointment schedule, the parties involved (endoscopist, patient, and examination room).
We chose the "Kronos" program, developed at GUH, which couples the patients' and physicians' agendas, and automatically handles the

examination room schedules and sends a personalised written instruction for preparation to the patient (ambulatory) or nursing station (inpatient) concerning the particular examination.
"Kronos" automatically takes into account the disposability of the endoscopist according to his/her own agenda.
The application of the system for inpatients and outpatients has been successful, confirming our impression that "Words fly, writings apply". Written convocations are here to stay.