Prince Charles Hospital Day Surgery Unit
Operational Policy

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APPROVED BY: Theatre Users Group
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Policy Definition

A policy is a high level overall guide, which sets the boundaries within which action will take place, and should reflect the philosophy of the organisation or department.

It provides a prescribed plan for staff to follow, which should not be deviated from.
1. **Purpose**

At a time when great emphasis is being placed on meeting demanding targets in relation to waiting times, hospital capacity continues to dominate the health agenda in Wales.

Day Surgery can make a significant contribution to increasing surgical throughput and this potential needs to be considered in the context of the overall health agenda in Wales and more specifically in the context of:

- Patient centered care provision and choice.
- Increasingly demanding waiting time targets.
- Provision and use of capacity.

(Day Case & Short Stay Surgery, BADS, May 2011)

Where clinically appropriate, day surgery delivers benefits for patients undergoing elective surgery. It reduces the length of stay in hospital, thereby lowering costs to the NHS, and the risk of hospital acquired infections.

(Making better use of NHS Day Surgery in Wales, Wales Audit Commission, 2006).

A number of definitions of a day case are available. This definition is from A Guide to Good Practice: Day Surgery in Wales, WAG, 2004,: BADS 2011.

A day surgery episode requires the elective (or planned urgent/emergency) admission and discharge of a patient for surgical treatment in under 24 hours from the time of admission.

Processes should be in place to ensure that patients are discharged at the earliest possible opportunity

It is important to note that a definition of a day case needs to be considered within the constraints of available resources and requirements and can develop to meet Local Health Board’s requirements.

The main objective is to use the Day Surgery Unit to provide staff and facilities to care for patients who can safely be admitted for agreed surgical therapeutic and diagnostic procedures and discharged during the same day.

Designed for Life (WAG, 2005) states that 85% of patients should stay in hospital for under 48 hours. Treating patients through the Day Surgery Unit will help to achieve these government targets.
The purpose of this policy is to set out the Local Health Board’s approach to management of patients visiting the Day Surgery Unit.

2. Policy Statement
The Day Surgery is a self contained unit located in Prince Charles Hospital adjacent to main theatres and adjoined by a link corridor. The Unit comprising of reception, waiting lounge, consulting rooms and discharge lounge. The Stage two recovery ward area accommodates nine trolleys for patients undergoing GA procedures and there are separate dedicated areas for Ophthalmology/Urology. Managed specialties include General Surgery, Gynaecology, Urology, Ophthalmology, Orthopaedics and Maxillofacial, with additional services offered to ENT, Vascular and Medicine. The unit aims to deliver a quality effective, service delivered in a safe, secure, environment providing a high standard of care to all patients, clients and carers.

3. Principles
Patients want treatment that is safe, efficient and effective, and which provides the least possible disruption to their lives. Day Surgery gives this patient focused care. (Day Surgery Operational Guide, DoH 2002).

It is important that the population served by Cwm Taf LHB having Day Surgery receive care that follows the principles outlined in this document.

Those patients who are having procedures on the Audit Commission/BADS Basket of Procedures or the Local Health Board Specific Basket of Procedures (see appendix A) are identified as Day Surgery cases and directed towards the pre assessment process. This starts with a screening questionnaire followed by nurse led pre operative assessment.

When these patients are deemed suitable they are given a date for surgery following the guidelines from The National Booking Programme. The patient is fully informed of the procedure and risks prior to the surgery to comply with the Local Health Board Consent Policy.

The pre operative assessment process initiates the correct pathway for admission to the Day Surgery Unit. Ward care is provided pre and post operatively and theatre and recovery care is covered by Main Theatre policy, procedures and guidelines.

Suitable arrangements are put in place with verbal and written information provided as part of discharge process. Appropriate referrals are made to the community services, district nurses, social services or others as appropriate.

When complications occur, procedures are in place to deal with unplanned admission of day case patients. If a patient is not suitable for discharge
they become unplanned admissions and are managed via the bed management service.

Children will be treated on dedicated lists or on the first part of lists and separated from adults with operations performed by surgeons and anaesthetists with appropriate experience in the care of children.

Children are nursed in paediatric areas, with play facilities available.

Registered children’s nurses are available to care for children in day surgery.

4. **Scope**
The principles outlined in this policy apply to all medical, nursing, ancillary, administrative staff and managers. This document applies to all participants and users of the unit.

5. **Legislative and NHS Requirements**
The principles within this policy must be adhered to in order to meet patient expectations and to comply with the requirements of the recommendations set out in key documents, such as The Review of Health and Social Care in Wales (WAG, 2003), A Good Practice Guide – Day Surgery in Wales (WAG, 2004), Designed for Life (WAG, 2005), Making better use of NHS Day Surgery in Wales (Wales Audit Commission, 2006). Day Case and Short Stay Surgery (BADS, 2011).

6. **Procedure**

**SELECTION CRITERIA**

**Social Factors:**

a. The patient must understand the planned procedure and pre operative care and consent to Day Surgery.

b. Following all procedures under general anaesthesia, a responsible adult should escort the patient home and provide support for the first 24 hours. Journey should no longer than one and half hours For Local and regional anaesthesia an escort is also advised.

c. The patients’ domestic circumstances should be appropriate for post operative care.

**Medical Factors:**

a. Fitness for a procedure should relate to the patients health as determined at pre operative assessment and not limited by arbitrary limits such as ASA status, age or BMI. Patients with a BMI of 40 or
over will have an automatic pre-operative assessment appointment to determine the presence of co-morbidities

b. Obesity is not a contraindication to day surgery as even morbidly obese patients can be safely managed in expert hands, with appropriate resources. The incidence of complications during the operation or in the early recovery phase increases with increasing BMI. However, these problems would still occur with in-patient care and have usually resolved or been successfully treated by the time a day case patient would be discharged. In addition, obese patients benefit from the short duration anaesthetic technique and early mobilisation associated with day surgery. (BADS, 2011)

c. Patients with stable chronic disease such as diabetes, asthma or epilepsy are often better managed as day cases because of minimal disruption to after daily routine.

Surgical Factors:

a. The procedure should not carry a significant risk of serious complications requiring immediate medical attention (haemorrhage, cardio vascular instability).

Anaesthetic Management

Day surgery anaesthesia should be a consultant led service. However, as Day Surgery becomes the norm for elective surgery, consideration should be given to education of trainees as recommended by Royal college of Anaesthetists’ This requires appropriate training and provision of senior cover, especially in stand alone units.

Appropriate selection and patient preparation is crucial for Day Surgery.

National guidelines for patient monitoring and assistance for the Anaesthetist should be followed.

Anaesthetic techniques should ensure maximum stress and maximum comfort for the patients and should take into consideration the risks and benefits of the individual techniques. Analgesia is paramount and must be long acting but, as morbidity such as nausea and vomiting must be minimised.

Post Operative Recovery and Discharge

Recovery from anaesthesia and surgery can be divided into three phases:
1. **First stage recovery** lasts until the patient is awake, protective reflexes have returned and pain is controlled. This should be undertaken in a recovery area with appropriate facilities and staffing.

2. **Second stage recovery**. This should ideally be in an area adjacent to the day surgery theatre. It should be equipped and staffed to deal with common post operative problems (PONV, pain) as well as emergencies (haemorrhage, cardio vascular events). The Anaesthetist and Surgeon (or a deputy) must be contactable to help deal with problems. Nurse led discharge using agreed protocols is appropriate. (See Appendix B)

3. **Late recovery** ends with the patient has made a full physiological and psychological recovery from the procedure. This may take several weeks or months and is beyond the scope of this document.

All patients should receive verbal and written instructions on discharge and be warned of any symptoms that might be experienced. Wherever possible, these instructions should be given in the presence of the responsible person who is to escort and care for the patient at home. On discharge patients who have more than one hour’s travelling time after surgery should understand the possibility of pain, nausea and vomiting during a prolonged journey and be prepared to accept this risk (2). It is also vital that arrangements for emergency / post-operative care have been made at the final destination.

### 7. Training Implications

A wide range of staff are involved in day surgery and it is recognised that they may need to be supported in changing some of their working practices to allow day surgery rates to increase.

Staff should receive appropriate induction on appointment to the day surgery unit and continuing professional development through competency-based education and training. The competencies will need to enable staff to gain generic competencies in all areas of day surgery, as well as core specialties and skills.

Mandatory and Statutory training packages are in place and additional support provided for IT based services such as Myrddin/ Welsh clinical portal.

The clinical team has been developed to provide a multi-skilled workforce who can rotate within the areas of day surgery.

This provides a well trained, flexible, highly efficient and effective workforce. The benefits of multi-skilling are:
Staff appreciates and understands each other’s role and responsibilities, which leads to a more cohesive and motivated team.

Staff are better able to inform and educate patients and carers if they are familiar with the entire patient experience.

Flexibility of the workforce to cover sickness and absence.

The Local Health Board should assist surgeons with the move to day surgery. They should provide where required:

Specific training for the surgeons and anaesthetists in day surgery techniques and the advantages to the patients.

Day surgery leads participate in learning sets to facilitate spread of knowledge and optimal standards in day surgery.

The department has developed a training needs analysis (TNA) specific to day surgery which identifies the annual training requirements of all staff within the unit.

Training required due to the purchase of new equipment or the provision of new services is also identified on this TNA. The Main Theatre TNA covers mandatory and general needs.

8. **Review, Monitoring and Audit Arrangements**

This policy and associated documents will be reviewed every three years, unless other issues arise, and then it will be updated in line with any new or improved developments.

The monitoring of day surgery performance should be agreed and carried out through the Anaesthetics/Critical Care Directorate and covers issues at regular intervals throughout the year to improve performance. The Directorate meets monthly and discusses utilization/changes in service and feeds into, Clinical and Risk Governance, and Local Health Board committees and meetings as appropriate.

The Theatre IT System is able to provide information for continual audit of the Key Performance Indicators including throughput, start and finish times, utilization, did not attend (DNA) rates, cancellation of patients and of lists etc.

In addition information on unplanned admissions, and practice and district nurse referrals is collected.

Patient satisfaction audits and patient stories are carried out as well as audits of new services or developments.
Periodically, as indicated, audit of clinical issues such as pain control are carried out.

Feedback on performance is also provided by the regular Audit Commission Reports.

9. **Managerial Responsibilities**
This policy places responsibility on all levels of staff and their managers.

Overall managerial responsibility lies with the Chief Executive via the Directorate Structure.

The Day Surgery Unit lies within the remit of Acute, Critical Care and Theatre.

The internal organisation of the Unit comprises the Ward Manager who reports to, Senior Nurse Manager Theatres/Day Surgery who feeds back to Head Of Nursing, Directorate Manager/Clinical Director.

It is recommended that every Local Health Board should appoint a dedicated Clinical Director of Day Surgery to aid development of day surgery services, ensuring that consistent policies and guidelines are adopted across all surgical specialties.


The Clinical Director will lead on innovations and development in day surgery practice, and clinical governance with particular emphasis on clinical risk management and clinical audit.

The Day Surgery Manager will be responsible for the day to day management of the unit reporting to the Senior Nurse Theatre/Day Surgery.

The Waiting List Team manages the booking of patients.

Day Surgery has two dedicated ward clerks.

The recommended requirement is that Day Surgery should be represented at Local Health Board level by the Medical Director.

10. **Retention or Archiving**
Live version stored on the Local Health Board Intranet, archive versions kept by the Directorate Manager.
11. **Non Conformance**
All staff have a duty to comply with this policy.

All other policy issues including Risk Management, Health and Safety, Equipment maintenance and replacement schedules, financial arrangements and Clinical Governance and Quality Assurance are managed within the remit of the main theatre department.

Non compliance with Local Health Board policy and procedures may be dealt with by the Directorate and Human Resource Department under the appropriate Human Resource policy.

12. **Equality Impact Assessment Statement**
This Policy has been subject to a full equality assessment and no impact has been identified.

13. **References**

DOH. National Good Practice Guidance on Pre-Operative Assessment for Day Surgery 2002
Appendix A -

**BASKET OF PROCEDURES**

British Association of Day Surgery Trolley of Procedures 1999

1. Groin/abdominal hernia repair (Inguinal, femoral, umbilical, epigastric)
2. Excision breast lump
3. Minor anal surgery (Fissure/ simple fistula)
4. Varicose vein surgery (including bilateral, or long and short saphenous one leg)
5. Circumcision (including adult)
6. Release Dupuytren's contracture
7. Carpal tunnel decompression
8. Arthroscopy (including hip and shoulder)
9. Hydrocoele excision
10. Inguinal surgery children (orchidopexy & herniotomy)
11. Tonsillectomy in children
12. Correction squint
13. Bat ears/minor plastic procedures
14. SMR
15. Reduction nasal fractures
16. Cataract extraction
17. Laparoscopy+/- sterilisation
18. Termination pregnancy
19. TUR/laser/diathermy/limited resection bladder tumours
20. Pilonidal sinus excision and closure

*50% of the following should be possible as day cases*
21. Laparoscopic cholecystectomy (interval appendicectomy)
22. Laparoscopic herniorrhaphy
23. Thoracoscopic sympathectomy
24. Submandibular gland excision
25. Partial thyroidectomy
26. Superficial parotidectomy
27. Breast cancer wide excision with axillary clearance
28. Haemorrhoidectomy
29. Urethrotomy
30. Bladder neck incision
31. Laser prostatectomy
32. Trans cervical resection endometrium (TCRE)
33. Eyelid surgery including tarsoplasty, blepharoplasty
34. Hallux valgus ("bunion") operations
35. Arthroscopic menisectomy
36. Arthroscopic shoulder surgery (subacromial decompression)
37. Subcutaneous mastectomy
38. Rhinoplasty
39. Dentoalveolar surgery
40. Tympanoplasty
Audit Commission Basket 2000

1. Orchidopexy
2. Circumcision
3. Inguinal hernia repair
4. Excision of breast lump
5. Anal tissue dilatation or excision
6. Haemorrhoidectomy
7. Laparoscopic cholecystectomy
8. Varicose vein stripping or ligation
9. Transurethral resection of bladder tumour
10. Excision of Dupuytren's contracture
11. Carpal tunnel decompression
12. Excision of ganglion
13. Arthroscopy
14. Bunion operation
15. Removal of metalwork
16. Excision of cataract with / without implant
17. Correction of squint
18. Myringotomy
19. Tonsillectomy
20. Sub Mucosal Resection
21. Reduction of nasal fracture
22. Operation for bat ears
23. Dilatation and curettage / hysteroscopy
24. Laparoscopy
25. Termination of pregnancy
ORTHOPAEDIC OPERATIVE PROCEDURES

Carpal tunnel decompression
De Quervain’s release
Release of trigger finger
Amputation of the fingers and lesser toes
Interphalangeal fusion of the toes
Arthroscopic procedures
Tenotomy
Manipulation of joints
Removal of metalwork, including external fixators
Excision of ganglia, exostoses and minor lumps and bumps
Operation on ingrowing toe nails
Removal of foreign bodies
ORAL AND MAXILLO-FACIAL SURGERY OPERATIVE PROCEDURES

Deciduous extractions
Surgical management of supernumerary and impacted teeth
Excision of uncomplicated impacted teeth and buried roots
Exposure of unerupted teeth for orthodontic treatment
Excision or biopsy of oral lesions, hard and soft tissues
Enucleation of small cysts
Minor soft tissue surgery
Removal of sutures, bone plates and wires
EUA for suspected malignancy
Cryoblockage of peripheral nerves
Salivary ductoplasty and removal of calculi
Removal of skin lesion
Lingual frenectomy
Labial frenectomy
Scar Revision
GYNAECOLOGY OPERATIVE PROCEDURES

Uterine curettage
Diagnostic hysteroscopy
Endometrial ablation
Hysteroscopic resection of uterine septum
Minor vulval operations
Laser treatment of cervical and vulval lesions not suitable for outpatient treatment
Termination of pregnancy in the first trimester
Diagnostic laparoscopy
Minor laparoscopic surgery
Tubal sterilisation
Insertion and removal of hormone implants
GENERAL SURGERY / UROLOGY OPERATIVE PROCEDURES

Minor operations on the skin and subcutaneous tissues, including biopsies

Groin/abdominal hernia repair (Inguinal, femoral, umbilical, epigastric)

Inguinal surgery children (orchidopexy & herniotomy)

Excision breast lump, breast biopsy

Minor anal surgery (Fissure, simple fistula, sphincterotomy, anal warts removal and rectal polypectomy)

Pilonidal sinus excision and closure

Varicose vein surgery (including bilateral, or long and short saphenous one leg)

Circumcision (including adult)

Hydrocoele and Varicocele excision

Vasectomy

Laparoscopic cholecystectomy

Examination under anaesthetic (EUA)
ENDOSCOPIC PROCEDURES

Diagnostic urethro cystoscopy

Biopsy of bladder mucosa

Diathermy of bladder lesion

Urethral dilatation
OPHTHALMIC SURGERY OPERATIVE PROCEDURES

Corrective squint
Cataract extraction and lens implantation
Tarsorrhaphy
Blepharoplasty
Entropion and ectropion
Syringing and probing
Incision and Currettage of Chalazions
Minor oculoplastic procedure
Ptosis surgery
Electrolysis
## Appendix B - Discharge Criteria

<table>
<thead>
<tr>
<th>YES</th>
<th>N/A</th>
<th>NO</th>
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<tbody>
<tr>
<td>Vital signs stable, BP and Pulse satisfactory</td>
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<tr>
<td>Wound site checked for swelling or bleeding</td>
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<tr>
<td>Dressing, suture and drain advice given</td>
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<tr>
<td>Pain controlled on discharge</td>
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<td>Can walk unaided</td>
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<td>Identity bracelet and ring tape removed</td>
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<td>GP letter given to patient/sent to GP</td>
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<tr>
<td>Outpatient appointment given/sent to patient</td>
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<td>District Nurse/Nurse Practitioner arranged</td>
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<td>Tolerated fluids/diet or followed PONV guidelines</td>
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<td>Passed urine</td>
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<td>Adult escort/24hr care available</td>
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<td>Medication explained and given</td>
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<td>IV Cannula and ECG sticker removed</td>
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<td>Seen by Physiotherapist mobility aids given</td>
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<td>Discharge info and verbal advice given</td>
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<td>Patient contact number given</td>
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<tr>
<td>Operation sheet completed</td>
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