4. Management

Oral presentations

[61] 13 Years of Day Surgery
A. Machardy. Ballarat Day Procedure Centre, Albury, Australia

This paper is based on data from Albury Day Surgery, NSW, Australia, which was built and opened in 1992 and the changes that have occurred with the case mix during this period. The centre opened on the 10th August 1992, and operated on the first patient, the Day Surgery was then a 2 theatre, 10 bed first stage recovery, 10 chair 2nd stage recovery free standing centre in a rural area. Over the first 5 years our theatre cases were approx 1200 to 2000 per year and where limited to small cases:
- Dental
- D&C
- Beccs
- IVF

After the first 5 years of operating, more extensive procedures were being introduced this was due to the gradual acceptance of “Day Surgery”. During this period we promoted the benefits of Day Surgery to surgeons:
1. Fast Theatre turnaround time
2. Cost savings for patients
3. More patient contact

Surgeons started to embrace the benefits of Day Surgery, changing our case mix to a wider range of procedures with excellent outcomes:
- Arthroscopy Meniscectomy, Shoulder Repairs
- Nerve Repairs, Rhinoplasty
- Laparoscopic Burch Colpo suspension
- Facial implants, Oral
- Cataracts, Squint Repairs
- Tendon Repairs, Microsurgery
- Lap Hernias, Laparoscopy
- Vasectomy Reversal
- Endoscopy
- IVF

Albury Day Surgery has evolved over the past 13 years by:
- Working with Surgeons
- Embracing new technology
- Multi Skilling staff
- Education

Today Albury Day Surgery has 3 theatres, 14 bed first stage, 14 chair 2nd stage recovery areas, IVF lab, and operates on over 5000 patients per year, and has a profitable case mix.

[62] Day Surgery & oncology
A. Machardy. Ballarat Day Procedure Centre, Albury, Australia

Ballarat Day Procedure Centre, Victoria, Australia, opened March 2002, 3 theatres, 14 bed 1st recovery, 14 chair 2nd stage recovery, multi surgical day surgery. Free standing purpose built centre also has a IVF and Path labs.

After 18 months of operating we identified the need for Day Oncology. Mixing day oncology patients with surgical patients was a concern, to benefit all patients we extended the existing building.

The new extension consisted of:
1. 12 Chair Day room area
2. Private room with 3 beds
3. Clean & Dirty utility rooms
4. Sister station & Kitchen
5. Disabled toilet and shower
6. Four doctors consulting rooms
7. Office and reception areas

Prior to the extension the centre completed 3000 patients per year and 60% occupancy, the surgical side of the business was in its infancy and would grow, the infrastructure of the business was capable of catering for the growth in the surgical area and cater for the oncology patient.

The extra oncology patient numbers were 3600 for the year bringing the centre to a total of 6600 patients per year.

We increased staffing levels by 2.5fl and streamlined the staff and patients flow. Oncology patients are appointment based, arriving 15 minutes prior to admission, the reduction in waiting times was welcomed by patients.

Utilization and training of surgical nurses in the oncology area enabled the Centre to have multi-skilled staff for both areas.

The results from this Oncology extension have been exciting and have enabled the Day Surgery to:
1. Expand Services
2. Multi Skills Staff
3. Deliver a superior service
4. Improve patient & Staff flow
5. Improve occupancy and profit levels

[63] Innovation in performance review system
L. MacMillan. Montserrat Day Hospital, Brisbane, Australia

Starting as a private Endoscopy practice in 1996 with just six staff and one site, Montserrat has now grown to a Day Hospital organisation with forty-five staff, three sites and specialists from various areas utilize our theatres. Staff recruitment places a significant financial burden on an organisation of Montserrat’s size and therefore it is essential to attract staff that fit the culture.

Issues:
- High staff turnover rate
- Need to overhaul the recruitment/selection process

Objectives:
- Higher staff retention rate
- Develop a Strategy to monitor and support staff performance.

Method used:
- Processes developed revolves around Key Result Areas (KRAs).

KRAs start as an overview of objectives needing to be fulfilled.

- This forms a Position Description.
- Interviews are conducted by two managers, questions are derived from the KRAs.

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- Six month probation period is policy for all new staff (enables the employee and Montserrat to assess their position) and therefore it is essential to attract staff that fit the culture.

- Recruitments and selection process are key to attract staff that fit the culture.

- Six month probation period is policy for all new staff (enables the employee and Montserrat to assess their position and it became evident early on that three months is not long enough to assess a new employee’s ‘fit’, particularly as we have three separate Hospital sites that staff work across).

- Position Description, which was based on the KRAs, is expanded into a Role Definition.

- Employee’s performance is monitored and measured through Key Performance Indicators (KPIs) which form the Role Definition.

Specifically the role definition:
- Establishes priority of the KRAs.
- Develops key strategies to achieve KRAs.
- Identifies delivery timeframes.
- Nominates resources required, and
- Outlines the action steps the Manager feels necessary.

- Role Definition is negotiated by both parties (ensuring it is realistic and achievable), reviewed quarterly or when there is change in the position’s direction.
1. Employee reports back to the Manager on the KRAs, fortnightly. Their report identifies:
   - If the KRA has commenced or not,
   - What action steps have been achieved
   - Outcomes to date

2. Outcome:
   - Report is a working document demonstrating achievements and a highly successful tool for measuring performance.
   - Within the probation period, a group of employees is nominated to conduct a 360 degree appraisal/review.
   - Results are graphical presented which visually compares the individual's ratings to their colleagues. Results are provided in a feedback report (based on the KRAs).
   - Conducting the process before the end of the probation period provides time to improve before employment confirmation.

Managing multi-site Day Surgery in Australia

L. MacMillan. Monserratt Day Hospital, Brisbane, Australia

There are 243 Day Surgeries spread throughout Australia. Most are privately owned by Doctors working within the Day Surgery, and most rely financially on contracts with the private health funds. Approximately 30% of all private procedures for 2003/2004 were performed at Day Hospitals. The Monserratt groups of private Day Hospitals are located across three Brisbane sites in Queensland, and have been operational since 1996. I was fortunate enough to drive the design and development of each and now have a forth currently underway. My career has seen me work my way from an Endoscopy Nurse, to Charge Nurse, to Practice Manager and have now fulfilled the role of CEO for 3 years. The role as CEO in this environment is extremely diverse and many 'hats' must be worn throughout the day.

Major issues to deal with externally:
- Sourcing Medics to utilize the operating theatres
- Recruitment of Gastroenterologists
- High expectations of accrediting Body – Australian Council of Health Care Standards

Major issues to deal with internally:
- Managing growth and change
- Retaining Staff
- Governance issues
- Risk
- Expectations with medical records reporting
- Pressure on internal resources in alignment with budget
- Multi-skilling staff

Rely on for communication:
- Sitting on external committees
- Networking with other Facilities
- Benchmarking
- Memberships of organisations
- Support groups

I would like to share my years of experience of this specialised area with you.

The streamlined clinical pathway

S. Kleinhans. Monserratt Day Hospitals, Queensland, Australia

Objective: To respond to our customers' feedback by reducing the time they spend in our facility we set the following Key Performance Indicators:
- To have 80% of procedure patients in the procedure room within ten minutes of their appointment time.
- To discharge 99% of our patients within 1.5 hours of their appointment time.

Methods used: In administration, we had to upgrade our computer system, streamline our bookings procedure, set up a call centre to handle bookings across 3 sites, develop an efficient dictation system and improve the billing process.

In the clinical area we reviewed our clinical pathway forms, changed the admission process, reviewed the sedation drugs we were using and started using carbon dioxide to inflate the bowel rather than air.

Results:
- The total facility times are down to an average of 1.8 hours.
- 90% of our patients are now in the procedure room within the ten minutes required.
- Our administration and clinical staff have learned to work as a team to achieve these goals and there is friendly competition between the 3 sites to see who does the best job.
- Our most recent patient satisfaction survey reflects a positive change.

Conclusion: By using continuous quality improvement strategies and change management it was possible to improve the service we provide to our patients and in so doing create efficiencies in the business.

Australian Bali memorial eye centre, the project

E. Zambotti. Lions Eye Institute of Western Australia, Australia

The terrorist attack in Bali on the 12th October 2002 was a great shock to the peoples of Australia and Indonesia. The Australian Government and Australian people were prompt and generous in providing assistance for the benefit of all casualties both Australian and Balinese.

To this end it was decided by the Australian Government to assist in establishing a memorial community eye centre for the Balinese people.

The Australian Bali Memorial Eye Centre will be a stand-alone facility constructed by Ausaid and managed jointly by the Bali Provincial Department of Health and the John Fawcett Foundation.

The new centre will expand the scope of existing work of restoring eyesight to the Indonesians free of charge undertaken by an Australian Mr John Fawcett in Bali since 1989. The centre will also provide training for Ophthalmologists and Allied Health Professionals which will increase the number of Indonesian doctors able to perform cataract and implant surgery.

This paper will examine how cultural differences can be overcome to allow an International body of personnel to assist in the construction, establishment and operation of a centre which will provide total eye care to the poor of Indonesia while at the same time establish links to major teaching hospitals in Australia. I will also discuss the ongoing commitment of the John Fawcett Foundation in this project and what long-term strategies must be put in place by the Bali Department of Health to generate revenue to meet future operating costs.

Building and setting up an Ophthalmology Day Surgery Centre

E. Zambotti. Lions Eye Institute of Western Australia, Australia

Day Surgery today in Australia accounts for 70% of all operating cases and has become a very competitive environment. In the field of Ophthalmology this is particularly so.

Designing and building a private facility presents unique challenges, and requires a team approach if you are going to have a successful business. Patient care must be your priority when making any decisions during your planning and designing stage. Advanced technology comes at a cost and one of the main challenges is to build a centre that offers the very best patient care and is cost effective.

High volume, rapid turnover of mainly healthy patients should be one of your primary strategies. Thorough pre planning and critical analysis prior to building cannot be over emphasised. Even if your centre is "not for profit" it is mandatory to make a profit as this will assist you in any future developments and funds may be transferred into areas such as research and development.
This paper will look at what is required for a successful Ophthalmic Clinic, Day Surgery and Laser Vision centre to operate in this very competitive environment.

58 Laparoscopic gastroplasty for obesity: outpatient versus inpatient management

Academic Hospital Vrije Universiteit Brussel, Belgium

Laparoscopic adjustable gastric banding (LAGB) has recently been introduced as an ambulatory procedure. In this prospective study we compared 25 patients undergoing LAGB in an ambulatory setting with 25 controls who preferred the same procedure to be done in a typical 2-day hospital stay. The aim of the study was to identify factors which incited to an overnight stay after a gastric banding.

Results: Data from patients with an ambulatory LAGB versus inpatient controls: age (years): 35.3±2.1 vs. 41.7±1.9 (p=0.004, S); gender (female/male ratio): 23/2 vs. 18/7 (p=0.06); BMI (kg/m²): 40.0±0.9 vs. 40.6±1.1 (p=0.72); operating time (minutes): 89.0±3.1 vs. 97.2±5.8 (p=0.22); hospital–home distance (km): 22.4±3.2 vs. 21.7±3.6 (p=0.88); co-morbidities (number per patient): 1.68±0.74 vs. 2.40±0.87 (p=0.003, S); and previous abdominal surgery: 0.56±0.14 vs. 0.64±0.15 (p=0.70). The total cost of the procedure was 1850 vs. 1983 Euro. The mean time lapse between the end of the operation and discharge from hospital was 9±0.3 hours in the ambulatory group and there were no readmissions.

Conclusion: 1. LAGB for obesity may be performed on an ambulatory basis without complications.
2. Only advanced age and higher co-morbidities contributed significantly to the choice of an overnight stay for LAGB.

59 Surgical training in day surgery units

A. Björn. Danderyds Hospital, Stockholm, Sweden

In 1996, due to changes in the organization of Stockholm’s health care, the ENT clinic at Danderyd’s Hospital became a day surgery unit, linked to Karolinska Hospital. The fusion of two full-equipped ENT clinics ended up in one large ENT department, consisting of one high specialized unit (at the Karolinska Hospital) and one unit at Danderyd’s hospital, with an out-patient clinic and day-care surgery. Since Karolinska Hospital is a university hospital with educational and research criteria, which in general require skilled surgeons. A number of changes were made in order to obtain safety during training. The most important changes were made in the weekly schedule, allowing one of the senior staff extensive flexibility in order to be free for tutoring both at surgery and at the polyclinic. The tutoring position rotated between the senior physicians during the week. A readily available tutor resulted in more opportunities for the residents to increase their surgical skill with more advanced cases, but also to perform a great number of basic surgery. Mean-time the senior staff performed more advanced surgery, including soft tissue surgery, middle ear surgery and functional endoscopic sinus surgery, with residents as assistants. A prerequisite for this organization is, as in our case, that all staff, including nurses and anesthesiologists, are positive to education and regard it as one of the most important tasks for the unit. When evaluating training of residents in a day care unit, we found that the residents were very pleased with the changes and that after half a year at the day surgery unit they were able to independently perform all basic surgery required and had knowledge of and had tried more advanced surgery under supervision. Still we managed to keep the production goals.

During the same period evaluation of patients’ satisfaction with the treatment and results did not decline. No serious adverse events involving residents were reported. Our conclusion is that it is possible to develop an organization including surgical training in day surgery units with unchanged high quality.

70 23 hour surgical short stay facility: Improving the service

R. Agnoli, L. Wilson, A.M. Bhargava. King George Hospital, Essex, UK

Background: A 23-hour surgical admissions pathway was recently implemented in our District General Hospital in order to (i) reduce the 25% of scheduled operations cancelled on the day of admission, (ii) decrease the length of, and numbers on, the in-patient waiting list, and (iii) to improve Day Unit bed use. This relies upon using ring-fenced beds for a 23-hour stay. Objectives: We audited pathway utilisation, achievement of shortened stay, and the effect on cancellation rate.

Methods: We audited the progress of 46 patients through the pathway during June and July 2004. Appropriate allocations, the number and reasons for cancellation, length of stay, and achievement of a new system of nurse-led discharge were assessed.

Results:
- 30% achieved a stay of 23 hours
- 42% stayed for 24–30 hours
- 18% stayed for 31–48 hours
- 9% stayed for >48 hours
- 72% of patients could have achieved a stay of 23 hours if the doctors’ post-operative instructions were clearer. Seven patients were incorrectly allocated and 2 patients were cancelled.
- 70% of patients had a successful nurse-led discharge.
- In-patient bed unavailability dropped from 142 to 24 compared to the preceding year.

Conclusions: Nurse-led discharges are crucial in realising a 23-hour discharge protocol. The ability to carry out operations within a 23-hour stay facility offers the solution to long waiting list numbers and times, and negates a 3 to 4 day in-patient stay. Full utilisation of the pathway would result in an extra 9 in-patient beds being freed-up per day in our District General Hospital.

71 Why a medical director of an ambulatory surgery unit should be interested in value analysis and process reengineering

M. Constantini, G. Bettelli. Hospital University of Pavia, Italy

To save money is always important, all the more so in leaner periods. Current circumstances are demanding: many Italian and European Health Organizations have recently encountered financial difficulties, and this trend seems to be extended at world level.

A rise in value is a must today in many human activities, and medicine and surgery are no exception: Health Organizations pay their "non conformities" in terms of rework loops until Customer satisfaction is obtained, if at all. Instead, the relief of unnecessary costs may have ultimate importance, resulting in a combination of:
- higher benefits for the Organizations (in terms of costs and operation safety)
- higher value for their customers, the patients (in terms of safety, treatment quality and costs)
- potential growth in the “market” of new therapeutic approaches

Competitive advantage for reengineered Health Organizations. Successful organizations develop performance management plans that sort out not only by identifying customers, stakeholders, and their needs, but also by clearly pinpointing their processes and choosing competent and responsible process owners. Process owners in Day Surgery – in their effort to reengineer and revalue their processes – should rely on adequate infrastructures and facilities, triggering new channels of interactions among clinic, technology, architecture organization, economics, etc. The contribution, which develops and updates a contribution to the 5th IAAS Congress (International Association of Ambulatory Surgery) in Geneva,
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A rise in value is a must today in many human activities, and medicine and surgery are no exception: Health Organizations pay their "non conformities" in terms of rework loops until Customer satisfaction is obtained, if at all. Instead, the relief of unnecessary costs may have ultimate importance, resulting in a combination of: higher benefits for the Organizations (in terms of costs and operation safety) higher value for their customers, the patients (in terms of safety, treatment quality and costs) potential growth in the "market" of new therapeutic approaches competitive advantage for reengineered Health Organizations. Successful organizations develop performance management plans that sort out not only by identifying customers, stakeholders, and their needs, but also by clearly pinpointing their processes and choosing competent and responsible process owners. Process owners in Day Surgery - in their effort to reengineer and revalue their processes - should rely on adequate infrastructures and facilities, triggering new channels of interactions among clinic, technology, architecture organization, economics, etc. The contribution, which develops and updates a contribution to the 5th IAAS Congress (International Association of Ambulatory Surgery) in Geneva,
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investigates specifically new inputs in facilities design, and in day surgery facilities design in particular, coming from the two great contemporary drivers: the en oule approche (new approach) and the unprecedented change in work organization. The “new approach” (a performance and customer/user oriented approach) originates as a tool to easy international trade (ISO standards), as a mean of protection of European citizens/customers from common market risks (Building directive 89/106 and in European harmonized standards), and as a way to enhance marketing abilities in mature markets as well. The “great changeover” on the other side is investigated with growing interest by major businesses and management schools: the Harvard Business School, the MIT Business Departments and the London Business School among others. PuntOpera process re-engineering as the way to improve efficiency of organizations and efficacy in customers' substantial satisfaction and are evaluating benefits and consequences in order to increase competitiveness. Let's not forget that this magazines advertise, aside coronary heart-bypass, hernia surgery at 489$, Cataract extraction at 556$, and other DS surgery at fixed price. Day Surgery structures and organization are strictly part of the business, and the Patient/Consumer is the focus both of medical treatment and of engineering/architectural solutions: patients in fact appreciate with increasing frequency complex parameters beyond therapeutic efficacy, such as staff dedication, stress reduction, time-waste decrease, hospital space and appearance and functionality. On their side, DS facility managers and operators are confronting with concepts such as global costs (instead of buildings costs or “instant” running costs) and value (instead of price). Hence, value is the reason why - more than ever - planners’ job is to evaluate and define “where”, “when” and “how” activities and processes should be allocated in view of safe operation, full work flow and patient’s comfort. A few cases, with updates, will be presented and shortly discussed as result examples of this approach. Moving from those cases, a basic concept will be stressed and developed: “Briefing” with facility managers, medical directors and operators, along with a deep comprehension of the processes, is the key phase of the design process of hospitals in general and of Ambulatory Surgery facilities in particular. A lengthy, accurate briefing deeply involving the staff is requested: the clinician is the key source, and engineers and architects should tailor on their shoulders (and patients’ shoulders) a facility working as a safe, agreeable, friendly and efficient “machine”: the Ambulatory Surgical Centre design has to be doctors’ and managers’ design as well as the architect’s and the engineer’s.

72 Evaluation of the reasons for cancelling outpatient surgery in a multidisciplinary unit of a public university hospital

H. Logerot, H. Noel, M. Frank-Soltysiak, J. Langlois. Bicêtre University Hospital, France.

Objective: To analyze the reasons for cancelling interventions in an exhaustive four-year series, and to propose a system for typifying the causes identified.

Method: In cases of cancellation, before or after the arrival of the patient, information concerning the cause of cancellation was systematically collected. We analysed changes in cancellation rates and typed the causes identified.

Results: Cancellation rate increased from 10.5% in 2001 to 14.9% in 2004 (p < 0.001). We analysed about 1460 cancellations, which we classified according to their cause: 1) medical reasons (36%), 2) patient-specific reasons (34%) and 3) organisational reasons (29%). The proportions of cancellations for each type of reason varied: patient-specific reasons decreased whereas medical and organisational reasons increased in frequency.

Discussion: The mean proportion of cancellations was 12.4%, consistent with reported cancellation rates. The rise in cancellations in this period may be due to improvements in recording, increases in activity and the probable broadening of indications. This probably accelerated treatment, reducing the time available for information and explanation, which are indispensable. Furthermore, the broadening of indications and confidence in the structure and its functioning may have led to the registration of more fragile patients, resulting in secondary cancellations. Many cancellations had mixed causes (organisational and patient-specific). For example, a “patient-specific” cancellation might be due to insufficient explanation or patient negligence.

Conclusion: Study of the causes of intervention cancellation, particularly for organisational causes, is essential to assessment of the structure’s performance. Periodic analysis of this indicator therefore constitutes a key means of improving service quality.

73 A national approach to improving Day Surgery

S. Penn. NHS Modernisation Agency, Leicester, UK.

In September 2002, the British Department of Health launched a Day Surgery Programme through the NHS Modernisation Agency, to improve the quality and quantity of day surgery being performed nationally. The Programme has now been running for two years. As the National Programme Lead for Day Surgery, the author of this paper will describe the approach taken as a joint strategy between the NHS, Modernisation Agency and Department of Health to assist all Trusts in improving their day surgery rates with the aim of 75% of all elective surgery being carried out on a day case basis as described in the NHS Plan.

The objectives of the National Strategy were, and continue to be to:

- Support Strategic Health Authorities (SHAs)/Trusts/Primary Care Trusts in delivering the levels of day surgery contained within Local Delivery Plans and therefore make a significant contribution to meeting the access targets.
- Improve patient care, by ensuring patients are treated by skilled staff at the right point in the system.
- Increase the efficiency of the NHS by facilitating the appropriate shift from inpatients to day surgery, outpatients and primary care and by increasing the productivity of day surgery units.
- Support Clinicians and staff to adopt best practice in Day Surgery. The Programme was clinically led. The initial steps taken were to appoint clinical champions within each SHA and work began to develop plans to promote day cases across whole health economies. It was agreed that SHAs should determine the right approach for their sectors with their Clinical Champions and local health economies. Support from the Modernisation Agency Day Surgery Team was then tailored to local needs. In this way it was felt that the programme could be owned more locally. The Day Surgery Team gave specific intensive support to a few Trusts where significant gains could be made.

The achievements of the Programme have been to develop tools for SHAs and Trusts to use locally to help them ascertain baseline levels, improvement tools, the publication of a Good Practice Guide, the hosting of national and local specific speciality events, and a leadership programme for the clinical champions.

Improvements to day surgery have been made and the main benefit of a national approach has been to raise day surgery on managerial and clinical agenda.

As from April 2005 the Modernisation Agency work will focus on leading edge thinking around elective care and will move away from hands-on improvement. However, the work that has been done over the last two years will continue as it will managed locally by the SHAs, the clinical champions and the DH.

74 Follow-up study: Measurement of effective learning in distance education for nurse Continuing Professional Development (CPD)

C. Castoro, C.A. Drace, M. Zucchetto, S. Merigliano. University of Padua and TRASTEC, Sopa, Padova, Italy

The nursing profession is one of the categories of health workers which requires constant updating of knowledge and clinical practice in order to administer "state of the art" medical care to patients. Many Continuing Medical Education (CME), or Continuing Professional Development (CPD), events are aimed at this category. Italy is the only
European country whose national CME program includes physicians, nurses and other health professionals, public and private. In some countries, like the UK and the USA, nurse CPD is handled by nursing professional organizations while other countries have no mandatory programs for the nursing profession. Distance education for CME has, by now, become an alternative to the traditional congress or convention for satisfying professional development requirements. It allows interactive self-paced learning as well as virtual classroom environments either at home or in the workplace. Distance education has been shown to be an effective mode of delivery nursing education.

Access to CPD is a challenge for nurses who have work and family responsibilities and may live in unserviced areas. The SkyMed Project, co-financed by the European Space Agency, developed a new teaching and communication model for medical distance learning and for CME. The project consortium developed course contents in collaboration with the International Association for Ambulatory Surgery and the Italian Federation of Day Surgery (FIDS). “Day Surgery Nursing” was the first experimental course of the SkyMed project. The computer based training course (CBT) took place fall 2003 in 7 multimedia classrooms at the main hospitals of the Veneto Region, Italy. Students met 2 hours, 2 afternoons a week for self guided participation and study. The foreseen duration of the course was 16 hours and 34 nurses participated in the SkyMed CBT. Upon completion of the course participants were asked to complete a questionnaire evaluating certain aspects of the course and were interviewed over the telephone. Participants expressed enthusiasm about the course and felt that others would benefit from this course (score 3.17 and 3.24, respectively, scale 1-4: 1 = strongly disagree – 4 = strongly agree). Analysis of completed questionnaires indicated an overall acceptance of the learning model and usefulness of distance education (score 3.52 and 3.61, respectively). On the other hand, difficulties were found in the nature of the contents; they were either too medically rather than clinically oriented or the cultural aspect varied too much from the local nursing situation (Day Surgery nursing in UK vs. that in Italy). If a CME program is to be successful, there must be active participation of all involved, irrespective of the educational format, with the presentation of up-to-date, clinically relevant material. Success can be gauged in terms of the extent to which the knowledge gained is retained (immediate and long-term), and applied in the health care setting with measurable improvement in patient health or workplace dynamics. In order to ascertain the effectiveness of the SkyMed nursing course a follow-up study is underway. This study will involve a questionnaire and telephone interviews aimed at assessing the application of concepts and practical instruction acquired after completion of the course. Results will be presented.

References


[2] Suter Sanzaro et al. (quoted in Distance learning: Using the Web as a Tool for Interactive CME. Kevin D. Horn MD. University of Pittsburgh Medical Center, Pittsburgh, PA, Nov 8, 1996).

75 UNE-EN ISO-9001-2000 Certificate for a major ambulatory surgery unit

M. Prats Maeso, L. Hidalgo, J. Barja Sanchez, X. Suñol Sala.
Hospital de Mataró, Spain

Background: Since the beginning of the activity of our Major Ambulatory Surgery Unit (MASU), Quality Assessment Programme has been reviewed in 1997 and 2001. Quality indicators were adequate in 2003 to obtain in 2004 the ISO 9001/2000 certificate.

Material and Method: All the processes of the surgical procedures done in the MASU were revaluated in 2003. Quality indicators, that have been used since 1994, were modified and a new ones were included, in order to get the process completely. Objectives for every indicator were determined.

Results: The process in the MASU was divided in five:

- Selection of the patients, that includes the selection by the surgeon, selection by the anesthesiologist and surgical daily programme. Indicators considered were: patients rejected by the anesthesiologist (0.79%), changes in the surgical programme and delay of the operation after surgical indication by the surgeon.
- Inpatient process: cancellations (1.41%), time for the patients waiting for surgery over 60 min (7.9%) and events in the inpatient process.
- Operative process: Recovery stay under 90 min (3.6%).
- Discharge process: postoperative mean stay (102 min) and early admissions (1.3%).
- Postoperative follow-up: reoperations (0.25%), emergency evaluations (2.7%), outpatient evaluations (1.6%), late admissions (0.2%), postoperative pain under 3 measured by analogical scale of pain (5.2%) and analysis of the satisfaction questionnaire of the patients.


Posters

76 Oncological management in hospital based ambulatory surgery

M. Cherubini. Azienda Ospedaliero Universitaria di Trieste, Italy

Objective:
1. To value the possibility to perform a neoplastic screening in an ambulatory surgical unit.
2. To value a group of oncological lesions excised.

Methods:
1. The patients sent for an consultancy or ambulatory oncological clinical visit were examined. Signs were searched referred to neoplastic screening, with the clinical exams prescription, cytological and/or biopical assessment. Endoscopy with histology, ultrasonographically guided biopsy, bronchoscopy and biopsy were prescribed and executed in short.
2. The suspected lesions were removed and histology was performed.

In both the groups the risk factors and the staging were defined.

Results: The checked lesions were: breast (176), colorectal (79), lung (29), stomach (15) cancers. They were quickly treated after histology and stadiation. The 2nd group concerned 109 patients directly operated in ambulatory surgery for suspected neoplastic lesions. These were subdivided into: periaerolar non Hodgkin lymphomas and pseudolymphomas (7), glomus tumours (12), schwannomas and Abrikossoff’s tumours (7), non melanomas and melanomas (57), Merkel tumors (2), metastatic excisions (22), Kapoor’s sarcomas (2).

Conclusions: It is highlighted the usefulness of the neoplastic lesion evaluation and stadiation before operation. There is the possibility of widening the volume of surgical traditional operations with oncological diagnostic and therapeutic procedures, in order to obtain cytological or histological exams, the stadiation, the operative risk factors evaluation. The direct biopsies and the excisions of suspected areas are possible and useful in hospital based ambulatory surgery. All these procedures obtain higher level of patient satisfaction, appropriate selective diagnosis and treatment before admission, the valuation of risk factors, also in the old age, with the reduction of hospitalization and the decrease of the health costs.

77 Ambulatory Surgery and dental hospital Day Unit

P. Thomaen. Newcastle Dental Hospital, UK

Background: A wide range of patients attend the Oral Surgery Day Unit at Newcastle Dental Hospital. These are mainly fit adults and children for elective dento-alveolar surgery, but there is also a significant number of medically or physically disabled, or dental
phobic patients, requiring comprehensive dental treatment under general anaesthesia.

Methodology: A new purpose-built ambulatory care unit was opened at the Dental Hospital in 1999. A retrospective review was carried out in 2004 to characterise the overall patient base and to quantify operative activity during the period January 1999 to December 2003.

Results: A total of 9217 patients attended during this 5 year period; 53% were female and 47% male. Whilst a very wide age range was observed, between 1 to 83 yrs, the majority of patients were paediatric with 6561 in the age group 1 to 10 yrs. Unsurprisingly, extraction of teeth and dento-alveolar surgery comprised 89% of all procedures, although a gradual fall in numbers was observed over the 5 years. Other oral and maxillofacial surgery cases contributed only 3% overall, but the number of these procedures has risen. Restorative and paediatric dentistry cases accounted for 8% of activity.

Conclusions: Profiling attending patient populations and reviewing activity data helps optimise ambulatory care, and facilitates planning of future service provision.

78 10th Anniversary of the International Association for Ambulatory Surgery (IAAS)

I. Reydelet, Germany

Ten years ago at the 1st International & 3rd European Congress on ambulatory Surgery in Brussels (16–17 March 1995) the International Association for Ambulatory Surgery was founded.

The poster is a report about the IAAS history from the constitution till today and describes the different steps in the evolution, the successes within the last ten years and the projects for the future.

An important iconography completes the description and points at the importance of the IAAS particularly at The background – Chronology of formation
The first executive committee formed 15th March, 1995
The reason why was the association formed?
The achievements of the IAAS
The IAAS work in progress
The present membership
IAAS office
The International Association for Ambulatory Surgery (IAAS) can be reached c/o BADS, 35-43 Lincoln’s Inn Fields, London WC2A 3PE, UK.

79 Assessment and evolution after 10 years of activity in ambulatory surgery

R. Mansilla Folgado, D. Sintes Matheu, M. Pijoan Calonge. Hospital Municipal de Badalona, Barcelona, Spain

Objective: The AS has initiated its activity in our hospital in 1993, and has been increasing progressively like in the majority of the centres, after ten years of existence. Our objective is to assess the activity and quality indicators of AS analysing the causes of its evolution.

Material and Methods: Out of a total of 15,630 AS operations (during the period 1993–2003), the number and the causes of admission (211 in all), % of them (1.3%), the index of global substitution (44%), the distribution of the specialties and their evolution, have been assessed according to the characteristics of our Hospital.

Results:

Operations number and surgical specialities, 1994–2003:
- Vascular surgery: 23; Urology: 2681;
- Gynaecology: 1105;
- Ophthalmology: 5909;
- Orthopaedic and trauma surgery: 3179;
- General surgery: 2217;
- ENT: 516.

AS admissions 1994–2003 according to the surgical speciality:
- Vascular surgery: 1%
- Urology: 1%
- Gynaecology: 23%
- Ophthalmology: 34%
- Orthopaedic and trauma surgery: 17%
- General surgery: 23%
- ENT: 1%

Index of global substitution:
- 1994: 17%
- 1998: 28%
- 2003: 44%

ADMISSION CAUSES:
- Medical causes: 45%
- Surgical causes: 33%
- Anaesthetic causes: 11%
- Social causes: 11%

Conclusions:
1. Annual increase of the number of AS operations and a progressive diminution of the number of admissions and complications.
2. Very significant increase of Orthopaedic Surgery operations due to the introduction of the percutaneous surgery, that allows to make locoregional techniques of the foot. Ophthalmology, like in most of AS centres, is the specialty with a greater number of operations.
3. The extension of the schedule of the Unit until 9 pm has improved its performance, allowing activity in the afternoon.

80 NHS Elect – a UK approach to improving elective care through partnership


The National Health Service (NHS) is losing its monopoly on the provision of publicly funded healthcare. This policy shift challenges the NHS to radically improve productivity while forming partnerships with private healthcare providers. NHS Elect has been established as a network of NHS treatment centres (TCs) to realise the benefits of this new environment.

NHS Elect offers the following support to participating TCs:
- Specialist knowledge and expertise (overseas teams) – implementing international models of best practice.
- Specialist knowledge and expertise (NHS) – A network of NHS clinicians and managers who have pioneered new models of elective care.
- Model of care – A unified model of care is being developed across the network.
- Accreditation – NHS Elect will operate an accreditation process, assessing progress in implementing improved models of care.
- Links with wider programme – NHS Elect is part of a wider programme of systems reform. Member TCs will be supported in acting as pilot sites for developments in health policy.

The work of NHS Elect to date demonstrates a number of benefits including:
- Improved clinical care and patient experience – Patient satisfaction is high and complication rates low.
- Improved operating efficiency – Streamlining the elective process.
- Access to expert networks – NHS Elect facilitates peer support and expert advice for all members.
- Provision of marketing and branding material.
- Objective accreditation – Enabling members to ‘benchmark’ their performance against other TCs.

81 The Initial experience of ambulatory surgery in Hungary

E.M. Gamal, A. Kovács. Budaörs Medicla Center, Budaörs, Hungary

The idea of one day surgery ODS in Hungary was initiated by the Hungarian Association of Ambulatory Surgery (HAAS) in 1997. Since that date the HAAS held three national congresses dealing with the possibilities of introducing this type of surgery
4. Management

in Hungary, and it lead all the negotiations with the authorities of healthcare, Health Insurance Company and other authorities which are concerned. The HASS provided all partners with the full international information and experience in all aspects of strategy, marketing and organisation. As a result of this, a permission was given to eight centres to begin the activities of ODS. All these centres are free standing centres all over Hungary. A majority of 251 activities were permitted to perform, in the field of general surgery (including proctology), orthopaedics (including arthroscopy and hand surgery), ophthalmology and gynaecology. The leading centre of ODS in Hungary now is the Budoros Medical centre, which is a free standing centre for ODS and other minimally invasive techniques, which started its activities in February, 2004. Since that date we performed 2500 operations, with no mortality and morbidity. We have a contracted expert staff of 24 specialists, together with the nursing and operation room staff. Our postoperative area consists of 14 surgical beds and we perform ambulatory surgery, 23 hour surgery and overnight surgery. Our paper is devoted to explain the circumstances of beginning and the strategy of developing ODS in Hungary, together with our safeguards to extend and propose it to other sectors of healthcare in Hungary.

82 Assessment of the satisfaction of professionals with a multidisciplinary outpatient surgery unit

M. Frank-Soltysiak, H. Logerot. Bicêtre University Hospital, France

Objective: To measure the satisfaction of professionals with a multidisciplinary outpatient surgery unit (OSU) and to identify dysfunctions in this structure.

Method: We carried out a transverse study of a sample of hospital professionals selected, by drawing lots, from the entire hospital staff (N = 682). An ad hoc questionnaire was developed with the aim of evaluating perception of the service received by the patient, and the organisation of work within the structure. The responses were studied item by item and satisfaction scores were calculated.

Results: The response rate was 58.2%. Of those questioned, 32.5% had already worked within the OSU and 92.5% were aware of its existence at the hospital. The satisfaction score for the service received by the patient was 86.9 (+21.8) whereas that for organisation was 74.4 (+23.1). However, 72.4% of those responding reported dysfunctions (the circuit followed by the medical file in particular). The professionals responding (99%) felt that it was essential for public hospitals to offer this type of activity, which 94% of professionals thought rendered the hospital more attractive to patients.

Discussion: The questionnaire was created from scratch because we were unable to find another evaluation of the satisfaction of professionals with outpatient surgery.

Conclusion: Studies of the perception of professionals constitute an essential element in the assessment of care quality and for correction of the dysfunctions identified. Hospital professionals expressed positive views concerning the service provided to patients and the organisation of this unit, supporting the development of this type of patient management.

83 The development of an Ambulatory Surgery Centre (ASC)

E. Alves, P. Rola, P. Lemos, R. Alegre. Portugal

Although non-emergency surgery performed on a day surgery basis is a fast-growing reality in Portugal, there are no independent ASCs operating at this time. In order to provide high quality health services within ambulatory surgery, it is necessary to develop appropriate and specific healthcare units for this kind of services. The purpose of this paper is to show how to develop the first independent Portuguese Ambulatory Surgery Centre (ASC) being developed and becoming a true symbol of innovation in the Portuguese National Health Service. It puts emphasis not only in the ASC and its characteristics, but also in all the development and designing phases of this healthcare unit. In 2003 an initial memo was prepared in order to develop the idea of building the first ASC in Portugal. In this particular case it was meant to be developed by Hospital Geral de Santo António, in Porto. The mentors of the project decided to study the feasibility and hired and independent external consultant to provide a market study and a financial feasibility study. Both indicated that the project would be of great success for both the Hospital and the National Health Service, but specially for the community it serves. The studies performed gave the project team the following information to both develop the building architecture and production capacity and to project its activity and financial demonstrations. Therefore, the future ASC will be organized in three major units (plus one special recovery unit), with the following structure:

<table>
<thead>
<tr>
<th>Description</th>
<th>Intervention rooms</th>
<th>Consultation</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Unit</td>
<td>Four major surgical suites and one minor surgery suite</td>
<td>Nine consultation rooms; Special minor surgical suite</td>
<td>Twenty-two recovery cabins; Three treatment rooms</td>
</tr>
<tr>
<td>Endoscopy Unit</td>
<td>Two endoscopy suites</td>
<td>One consultation room</td>
<td>Four recovery cabins</td>
</tr>
<tr>
<td>Ophthalmology Unit</td>
<td>One major surgery room and one Laser room</td>
<td>Five consultation rooms</td>
<td>Laser for diabetes treatment</td>
</tr>
<tr>
<td>Special Recovery Unit</td>
<td>–</td>
<td>–</td>
<td>Ten individual rooms; One treatment room</td>
</tr>
</tbody>
</table>

According to the market study this ASC will be able to perform 16,000 surgeries, 60,000 consultations and 6,500 endoscopies, within reasonable occupancy rates. These are projections made within the area that Hospital Geral de Santo António covers and would have to be revised if it was meant to any other healthcare institution. To develop an ASC every project team should perform the same feasibility studies as in this case because every project has its own specifications and needs according to a different reality. Also very important are the projected financial results for this ASC. The project team is developing a totally informatics healthcare unit, which together with innovative management methods and differentiated incentive plans will guarantee the necessary productivity and efficiency to provide an investment pay-back period of approximately 3 years. As specified above these achievements would also have to be studied and developed for each specific case by a specialized team.