Surgical Day Care Predicaments

An overview of the Jams & Pickles

By Lee Curell, RN, and Shelley Dalzell, RN, BSN

Today health care dollars are scarce and health care resources are stretched to the maximum. OR time is severely limited and there is a critical shortage of inpatient beds. Hospitals have been forced to look at ways of providing quality care, while also reducing costs. Day care surgery, or ambulatory surgery as it is sometimes known, is one of the answers to this dilemma.

Surgery in the USA

Year	% inpatient	% outpatient
1984	72%	28%
1994	34%	66%

Canadian statistics are similar to these USA figures.

In the short 10-year period, from 1984 to 1994, the percentage of inpatient surgery vs the percentage of outpatient surgery has completely reversed. In 1994, on average only 34% of surgery was done as inpatient surgery. Fully 66% was done on an outpatient basis.

Day surgery meets the needs of a stressed health care system. It provides service quickly, efficiently and economically. The financial savings for some procedures can be very high, (e.g. 60% savings on hernia repair).

Day surgery also meets many needs of the individual. Patients rest and recover more comfortably in their own familiar surroundings. The risk of acquiring nosomocomial infections is lessened as they spend less time hospitalized.

Another advantage to the patient is the convenience of day surgery. In today's society time is a precious thing and people want to get their surgery done and then get on with their lives ASAP. Ambulatory surgery does not depend on the availability of a hospital bed.

In the past, day surgery consisted primarily of minor procedures, (e.g. D&C, cystos, removal of lumps and bumps), done on healthy patients. Nowadays, Day Surgery procedures are becoming increasingly complex, as are the patients themselves.

Laparoscopic hernia repair, TUPR, tonsillectomies, Burch repair and parotidectomy are commonly done in the outpatient setting. I have read that biliary tract exploration, hiatal hernia repair, splenectomy and nephrectomy are among the operations that may be done as out patient procedures in the future.

The patients themselves are also more complex. Gone are the days when they were all ASA 1. It is now more the norm, than the exception, for patients to be ASA 2 and 3 or even 4.

Innovations in surgical instrumentation and techniques, (MIS surgery, lasers surgery, etc), and newer anesthetic drugs have made advances in surgical day care possible. The limits are continually being pushed and *'advances'* in SDCC must be carefully considered. Nurses as a group recognize that financial considerations, and simply being able to do it, are not the only criterion for setting the limits of day surgery.

Because the day care patients' surgical experience is compressed into hours, rather than days, the responsibilities and challenges faced by SDCC nurses are much different than those faced by nurses working in a main operating room.

In this presentation we will discuss some of the predicaments or dilemmas facing nurses in day care surgical areas. Some are jams and some are pickles.

JAM #1 - Pre-Admission Nurse

The type of patient accessing day care surgery has changed. In my workplace we found that patients with complex health problems were arriving for their surgery and we weren't prepared for them. This is how we dealt with this pickle.

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Cartoonist: Brad Dalzell, husband of Shelley.

In the past at Vancouver General's Surgical Day Care Centre, each case was approved, or not, by the anesthesia department. The anesthetist based his/her decision on the surgeon's patient history and the surgical procedure to be performed. Unfortunately surgeon's histories are not always complete.

Dealing with these issues, when the patient was supposed to be ready for surgery (with the OR staff and surgeon waiting) put a great deal of pressure on everyone including the anesthetist and the nurses working in the pre-op. It was often necessary to get stat blood work and EKG's, give meds, get reports faxed etc. etc. The end result was that sometimes the case was delayed, and sometimes the case was cancelled. This caused a lot of expense and frustration for everyone involved, including the patient.

We realized that our surgical day care needed a pre-admit or screening component, and two years ago a Pre- Admission nurse position was created.

Now the patient's surgical history, and a health questionnaire which the patient fills out in the surgeon's office, are forwarded to SDCC prior to the surgery date. The Pre-admit nurse reviews these and identifies actual or potential problems which could affect the patient's surgical experience or recovery. She contacts patients to clarify and get additional information about health related issues.

The Pre-admit nurse using her own clinical judgment, has the authority to approve ASA 1, and ASA 2 patients for day-care surgery. If the patient is ASA 3 or 3-4, she obtains information and test results and confers with anesthesia. Anesthesia either approves the patient for day-care surgery or refers them to the Pre-Admission Clinic for a thorough work up. Going to the PAC does not necessarily exclude a patient from having their procedure done at SDCC.

The Pre-Admit Nurse position came about initially from a need to screen patients with complex health issues. It was a transfer of function from anesthesia. The role however, quickly expanded and now has a large nursing component. Her role also includes:

- Liaison with the primary care givers for the "challenged" patients (mentally or physically challenged patients) and the elderly;
- Liaison with Home Care in the discharge planning process of certain patients;
- Identification of problems which could affect recovery or discharge;
- Advising patients re: preoperative medication requirements;
- Providing guidance for sequencing of the OR so that patients are best served; and
- Communication with other Day Surgery team members.

The Pre-Admit Role has been very successful at SDCC. The patients are better informed, the staff is informed about patient's health care issues and their needs before they arrive for their surgery, and anesthesia is pleased. The Pre-Admit role has helped us improve the care we give to our patients, increased our efficiency and decreased the surprises.

Jam #2 - Consents

Regardless of the group of nurses, it seems no nursing conference is complete without mentioning informed consent. Perioperative nurses plays a vital role with respect to informed consent, as they are often the last health care professional encountered by the patient before their surgery.

Is the perioperative nurse liable in an way if the informed consent process has not taken place?

The courts have ruled that the responsibility for obtaining informed consent for a surgical procedure remains solely with the surgeon. This role, by law, cannot be delegated to another.

How do we know that informed consent has occurred? A signed consent form is one physical piece of evidence that demonstrates this, however it is not sufficient, by itself, if there is an informed consent dispute.

The role of the perioperative nurse is to determine if the informed consent has been obtained and to validate the patient's agreement to proceed with the surgical procedure. Up until recently advocating for a patient with regard to informed consent was always an ethical obligation - now it is a legal obligation.

If a patient expresses to the perioperative nurse

uncertainty regarding the nature of the surgical procedure he or she is about to undergo- including the risks, benefits or alternative treatments - this could be an indication of a deficiency in the informed consent process. It is the role of the perioperative nurse to advocate for this patient promptly by notifying the surgeon of the patient's statements regarding their surgical procedure.

The perioperative nurse meets her legal responsibilities in the informed consent process by:

1. Validating that the informed consent process has occurred and that the patient is in agreement to proceed with the planned surgical procedure.
2. Secondly, by promptly reporting and documenting any discrepancies or inadequacies relating to the informed consent.

What would happen if you did not do this?

Failure to do so could result in a negligence charge against the nurse should there be an informed consent dispute.

JAM #3 Privacy, Confidentiality, Dignity

Surgery, even if it is considered 'minor', is a threatening experience to the patient. Emotions have direct effects on 'stress hormones' and they influence ones immune function. It has been shown that highly anxious patients have a slower, and more complicated post-operative course.

Highly anxious patients usually:

- Require more anesthetic drugs;
- Are more likely to experience greater post -op pain; and,
- Have delayed wound healing.

Interventions that reduce a patient's anxiety can have substantial benefits for not only the patient's mental health, but their physical health as well.

In a recent survey done at a Boston Hospital Ambulatory Department, patients complained of:

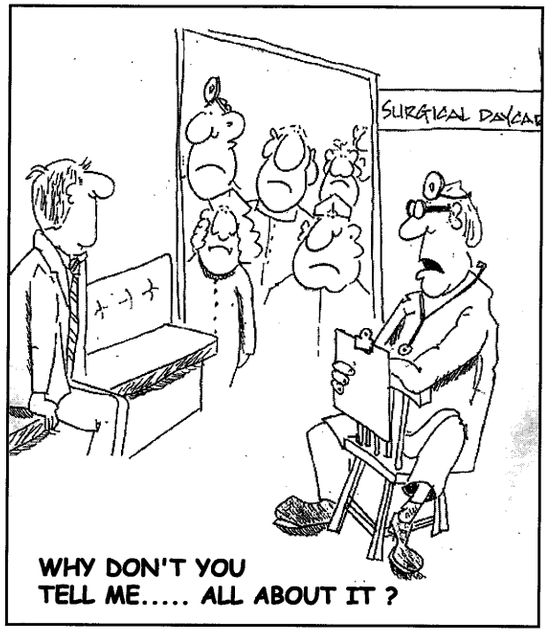
- Lack of privacy;
- Feeling part of a factory assembly line;
- Distress about leaving their family during the stressful pre-op time.

It is understandable that patients feel this way. Day Surgeries are busy units. Nurses are dealing with the issues of limited space, busy OR schedules, and having to interact with many different people.

Despite the limitations and demands it is important to remember the patient as an individual, and take steps to reduce the patient's stress. Some ways to address these issues:

• Family and Friend Involvement

There is ample evidence that social support can lessen the effects of psychological stress. Patients expect family/friend involvement. Respect and try to



accommodate this as much as possible. Depending of the culture, some patients arrive at the day care accompanied by many people. I recently had a patient arrive with 5 adults and 1 child. They were from an African country and were all over 6 feet tall! This was a huge number of people to accommodate in our small space.

• Provide and Protect Privacy

Many day-care areas were originally designed for inpatients and don't work for outpatient care. Take steps to change the physical environment if possible. At our workplace curtains separated patients. We changed that by having walls built where the curtains were, thus creating cubicles, and giving patients more privacy. This improvement was not that costly.

Protect the patient's privacy as much as possible by interviewing patients in a quiet, separate area. Speak in low tones if speaking with patient in an open area. If others are speaking about confidential patient information in loud voices be a patient advocate. Either discuss it with the person in question or bring it to your manager's attention.

Be aware of your environment - in a confined area don't discuss the patient if your conversation, including telephone conversation, can be overheard by the patient, or other patients and families. Go to an area where you can speak confidentially.

Keep confidential printed information covered, e.g. OR slates. OR slates have a lot of information that is available at a glance. They are sometimes left out in the open for all to see. Be careful with them.

Most hospitals now have patients walking to the

OR as opposed to being wheeled in a stretcher. Many patients are not aware of this policy, and some are shocked at this. One patient likened walking to the OR to walking to the gallows! Inform patients of what to expect, so it isn't a surprise. Also, ensure that when they are walking down the hall that they are covered, that the gown is not falling off their shoulder and exposing their 'parts'.

In a survey done at a Surgical Day Care, waiting was identified as one of the biggest issues for patients. Delays happen despite our best efforts, but keeping patients informed about delays will convey concern and respect for them, and reduce their anxiety.

In a recent letter to Ann Landers, an 80-year-old woman was complaining of waiting in a doctor's office, and being angry about wasting her time. Time is an issue - even if one is retired.

The Code of Ethics for RN's addresses both Dignity and Confidentiality. Essentially it states that nurses respect patients' privacy and confidentiality and intervene if others don't.

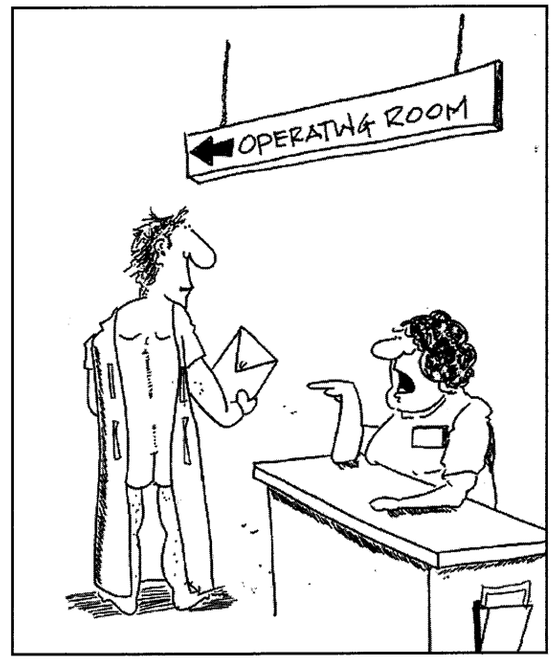
JAM #4 - Patient Teaching

Patient education has always been a priority for nurses ...and research has confirmed the many benefits to the patient...decreased anxiety, decreased post-operative complications, hastened recovery and patient satisfaction to name a few.

Surgical daycare nurses face a unique challenge in meeting patients' educational needs because they have to deal with what has been referred to in the literature as a "content squeeze". That is, they share a considerable amount of information with the patient in a short period of time .

Given the time constraints of surgical daycare, it is not appropriate to start the teaching of essential information on the day of surgery. Extensive patient education should happen in the surgeon's office, including the distribution of teaching pamphlets. If some patients are not receiving teaching pamphlets - this should be followed up with the doctor's office. If pamphlets are not available from the surgeon, perhaps this is something that can be changed. The sooner the patient receives information the better. Having written information available to the patient before their day of surgery allows the patient and family time to read and reflect on the information as well as formulate questions.

In an ideal world all surgical daycare patients would attend a Preadmission clinic. Realistically this service is not available to all and truthfully many patients do not like to take the extra time to

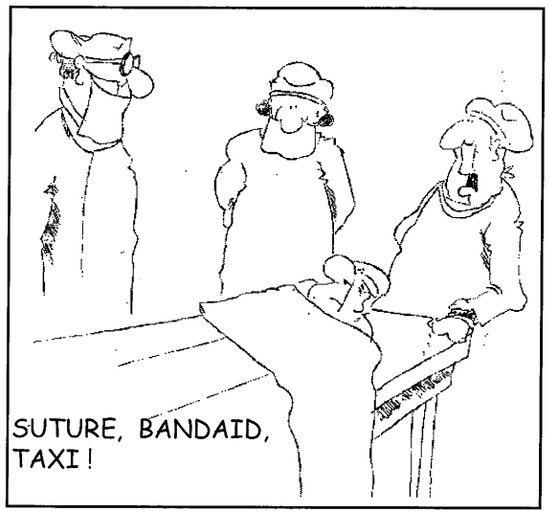


DOWN THE HALL ...2nd DOOR ON THE LEFT.

attend a PAC. Perhaps there is a need to develop a Pre Admission Screening Nurse, in your facility. One simple strategy used at the UBC site surgical daycare, is to have a nurse contact patients by telephone the evening before their surgery. During this telephone conversation, preoperative preparation is reviewed, as well as a few simple health questions. At this time the patient will often identify some concerns and ask many questions. This telephone call presents a new opportunity to reinforce preop teaching and even begin post op teaching. The staff have found that last minute alterations/cancellations have been made to the OR slate as a result of information obtained from these calls. In general, the staff feel that their day goes smoother for having had this contact with the patients.

Teaching pamphlets are mailed out by the hospital, clinic or handed to the patient in the surgeons office. Most Day Surgeries provide teaching pamphlets on the day of surgery. Written word reinforces teaching and gives the patient and family a quick reference. Audiovisual aids such as videos are also very helpful, and now Websites are surfacing as the new mode of patient education

One facility in the USA has collaborated with Harvard University to create an Ambulatory Surgery Nursing Website for the patients which provides information about the entire perioperative experience. This same facility has computer workstations available to the patient and family, and as well they provides nurses to help patients browse the website!



Preoperative Teaching

There are limited studies specific to pre and post-operative teaching in the surgical daycare setting. One study in 1996 asked patients what they thought was important to know prior to daycare surgery. Most patients believed information should be taught before their admission to the surgical daycare, with the exception of learning a new skill. This, they felt should be taught after admission.

The timing of your teaching will vary according to the patient and the environment. Some patients are so stressed when they arrive in surgical daycare they do not hear what you are saying to them. There is no concrete literature which dictates clearly when is the best time to teach. Having said that the perioperative nurse must seek every opportunity to perform patient teaching. Remember the "content squeeze " is on! Involve family or significant others as much as possible. Try to provide a quiet environment - pull curtains, and try to minimize interruptions (one of the most difficult challenges).

The most consistent theme with regard to patient education, is the importance of individualizing the content. Each individual has his or her own set of emotional needs, their own best method and best time for learning. Teaching should be tailored to each person, answering his or her own specific questions and providing resources. Teaching patients what they want to know is a clear way of improving the chances that they will actually learn.

When a patient does not understand English, arrangements should have been made, prior to admission, to have an interpreter present. The provision of interpreters may differ between facilities - for example, Surrey Memorial Hospital instructs patients in their Pre-admission pamphlets that if they do not speak English, they must bring their own interpreter with them on the day of surgery. By contrast, Vancouver Hospital & Health Sciences Center has a written policy stating that a qualified professional interpreter must be used and is available by telephoning their Interpreter Services Department.

Surgeon Preferences

The widest gap of knowledge occurs when a patient asks questions which depend on specific surgeon preferences. Questions like "When can I shower?", and "How long do I keep the dressing on ?" can be difficult to answer when surgeons have not all adopted the same protocols. If your answer is,"You will need to ask your doctor", this might leave a big gap in meeting the patient's educational needs. Whenever possible, try to provide specific answers to patient questions, prior to discharge.

The literature also states that learning occurs best in the context of a compelling presenting problem....so what are the potential problems facing this person ? ...ask them? Another interesting point to make is that patients often ask "How long will it take me to recover?". When a patient and nurse speak of recovery, they each have their own definition, Patients define recovery as being able to perform activities they performed before surgery.

One final group of studies involved "follow-up " telephone calls to patients to see how they were managing and how we could improve on the hospital care they had received.

A group of patients - all of whom had laparoscopic cholecystectomies were telephoned and asked what advice they would give someone who was about to undergo the same procedure. Their response was that instead of the nurse saying "...you should take it easy..", they would give more specific instructions to rest when they are tired and to help them reorganize their everyday tasks or activities to prevent overfatigue.

Some daycare nurses incorporate follow-up calls into their practice, and what better way to evaluate your teaching to evaluate the patient ? If you can't phone everyone - then pick a target group and phone them to see how they are doing after their surgery.

RNABC standard #3 speaks about "evaluating patient learning, evaluating patient outcomes and revising strategies as necessary". This is a quality improvement initiative.

We would like our practice to become more evidence-based and collecting data from patients following discharge is one important method. Follow-up telephone call can also glean important statistics regarding a patients pain management, how satisfied were they with their pain management in hospital, and what was their experience at home. Incidence of post-op nausea and vomiting is also an important indicator to monitor, not mention post-discharge bleeding. Telephone calls have proven to lead to early detection of complications.

Perioperative nurses are assuming greater responsibility than ever in pre and postoperative education, and with this responsibility comes a great challenge and an opportunity. The opportunity is to make a significant difference in postoperative outcomes by teaching useful, practical ways to help patients return to their usual selves. The challenge is to implement a way to measure this difference, otherwise, how will you know ?

JAM #5 - Post-Op Time & Space Constraints

Who's Job Is This ?

- Constant awareness of incoming...
- Pressure to move ones in the current space out...
- Constant rearranging of space...
- Pressured that the same space is needed by two different parties...
- Dynamic, constantly changing, time and space.

The characteristics just described belong to an air traffic controller, touted to be one of the more stressful jobs, but in fact it could also be describing the surgical daycare, only in daycare, you are physically 'in' the same space where all this 'space-juggling' is taking place.

Surgical workload is decided upon according to a number of variables: available staffing, types of cases, OR times, estimated discharge times. Basically an educated prediction is made regarding the workload that can be managed.

We have mentioned the increasing complexity of both the types of surgeries and the types of patient, both factors which may require a longer post-op stay, sometimes 3 to 4 hours.

Inevitably, the best laid plans do not always go smoothly. Delays in the OR, problems with post -op pain management, ponv, just to name a few situations, can suddenly result in a too many patients, not enough space, and sometimes, not enough staff.

What Can You Do ?

If you experience workload problems related to specific cases, make sure the manager is aware, or whoever is responsible for deciding workload. The workload problem may be due to an unpredictable event, but it could also be a trend worth noting.

Be a patient advocate with regard to management of pain and post-op nausea and vomiting (ponv). Ensure your facility uses protocols/preprinted orders for these problems, and are they adequate? Keeping on top of pain and nausea will help assist a patient's timely discharge.

Sometimes, you may wonder if a certain surgery or a complex patient should even be in surgical daycare... or would they be better served in an inpatient bed ? What do you do about this ?

Try to be proactive during the day by communicating anticipated problems so that staff can talk about 'contingency plans', ahead of time. If you are able, review tomorrow's slate and identify any workload concerns ahead of time.

Most importantly, **Know Your Limits**. Communicate to your peers and manager when you are feeling the workload is unreasonable.

JAM #6 - Discharge

Discharge following day surgery can be a challenge for the nurses. Pain and PONV are two common reasons for delayed discharge.

Pain - Intra-Op use of local anesthetic, nerve block, and the use of NSAIDS pre-op or intra-op, greatly reduce a patients need for Opiods in PARR. Opiods can interfere with bladder function and can increase the incidence of nausea and vomiting. Be a patient advocate.

Use PONV protocols. Ondansetron, dolasetron are more effective when administered near the end of the surgical procedure.

Systemic administration of steroids, (e.g. dexamethasone) has been recently reported to decrease both pain and emetic symptoms after day care surgery.

Going Home

What do you do when a patient's *responsible adult* does not come to take the patient home? What do you do if you find out **before** the surgical procedure that the patient has not arranged for someone to pick him up? Perhaps the patient is from out of town and staying at a hotel a block away. What do you do when the patient insists on going home unescorted?

Despite the fact that all of out patients are informed that they need an adult to take them home, these issues still occur occasionally. How do you deal with them?

Be aware of your institution's discharge policy and discharge procedure. Legal action can be taken if your institution policies aren't adhered to and harm comes to the patient. Community standards are looked at in legal cases. The community standard is:

- After a general anesthetic or sedation, patients must be accompanied by a responsible adult. A responsible adult should stay with the patient for 24 hours or overnight.

• Patients should be advised not to drive for 24 hours. There is no differentiation between having an anesthetic and having sedation. If a patient has had local only then they may drive him/herself home.

• If it is discovered **prior** to the procedure that a patient has no one to pick him or her up, then the procedure should:

✔ Be done with local only, or
✔ It should be cancelled, or
✔ The patient should be admitted.

If it is discovered **after** the procedure that the patient has no one to pick them up, then options are:

✔ Admit the patient, or
✔ Have the anesthetist or surgeon take the responsibility for the discharge.

If possible, have the anesthetist or surgeon assess the patient and write the discharge order. If that is not possible and you have to give the doctor a verbal assessment of the patient - over the phone, to get the discharge order keep in mind that you may have to defend your report in court. Be specific. Inform the doctor of all the medications the patient has received. Tell the doctor that the "patient meets all discharge criteria".

If the patient plans to leave without a person to accompany them, have them sign a waiver absolving the hospital of responsibility. **Documentation is important.**

Sometimes even if the patient meets all the discharge criteria you may be concerned about how the patient will manage at home. Perhaps the patient is elderly with and elderly spouse and you are concerned about them managing after a TUPR. Keep in mind that referring to Home Care is an option and can be initiated by nursing. If the referral is done later in the day, the patient will not be seen till the next day - but they will be seen.

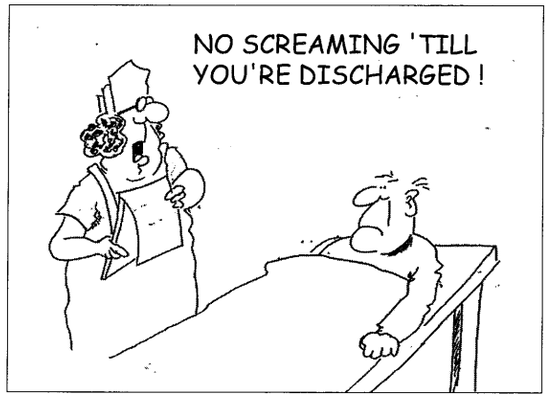
Inform the surgeon of your referral, as the Home Care Nurse will have to contact him/her if the patient needs any intervention.

A responsible adult must accompany the patient post general anesthetic or sedation. A responsible adult should stay with the patient for 24 hours or overnight.

Patients should be advised not to drive for 24 hours. There is no differentiation between having an anesthetic or sedation. If a patient has had a local only, then they may drive him/herself home.

Conclusion

Despite the widespread shift towards expanded ambulatory surgery, there has been little critical evaluation of the outcome of this service. We need to be more proactive in measuring nursing care outcomes in



ambulatory surgery. We need to look at satisfaction with pain management, incidence of ponv, infection rates, and prove that we are providing quality care.

Surgical daycare is a great place to work, it is stimulating, fast-paced and dynamic. It is also an area where you have to use a holistic approach. It really is the way of the future. ■

Recipe for Success

1. Preadmission
- Advocate for a nurse to telephone patients prior to admission.

2. Consent
- Validate the consent/promptly. Report & document discrepancies
- DO NOT attempt to answer a surgical patients' questions regarding the Risks, Benefits or Alternative treatments.

3. Teaching
- If possible, give written material prior to admission.
- Individualize your teaching/involve significnt others
- Review written materials/emphasize major points
- Avoid answering- "Ask Your Doctor".

4. Privacy
- Speak quietly... pull curtains
- Cover confidential material
- Be aware of conversations being overheard (including the telephone)

5. Post operative Care
- Know your workload limits
- Aggressive management of pain and ponv
- Follow-up calls/surveys

6. Discharge
- Know the facility's discharge criteria & policy
- Discharge order & nursing documentation
- Waiver for release of responsibility

The goal is to give good patient care by being a patient advocate and to be aware of the potential for liability in your workplace. Stay out of those jams and pickles.

Author Information

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