Day Surgery
Contemporary Approaches
to Nursing Care

Edited By

Dr Fiona Timmins
Senior Lecturer
School of Nursing and Midwifery, Trinity College Dublin
Ireland

And

Ms Catherine McCabe
Lecturer
School of Nursing and Midwifery, Trinity College Dublin
Ireland

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## Contributors

- Phillipa Ryan Withero

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*Philippa Ryan Withero*

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*Fiona Timmins*

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Contributors

Ms Anne-Marie Brady
Lecturer
School of Nursing and Midwifery
Trinity College Dublin
Ireland.

Ms Sharon Farlow
Theatre Service Manager, Bishop Auckland General
Hospital/Darlington Memorial Hospital County Durham and Darlington
NHS Foundation Trust, UK.

Dr Jo Gilmartin
School Of Health Care Studies
Baines Wing, University of Leeds
Leeds, UK.

Ms Catherine McCabe
Lecturer
School of Nursing and Midwifery
Trinity College Dublin
Ireland.

Ms Margaret McCann
Lecturer
School of Nursing and Midwifery
Trinity College Dublin
Ireland.
Contributors

Professor Robert McSherry
Professor Nursing and Practice Development
Practice Development Team
School of Health and Social Care
University of Teesside, Middlesbrough, UK.

Ms Kay Scott
Senior Lecturer
School of Health and Social Care
University of Teesside
Middlesbrough, UK.

Dr Fiona Timmins
Senior Lecturer
School of Nursing and Midwifery
Trinity College Dublin
Ireland.

Ms Phillipa Ryan Withero
Nurse Practice Development Coordinator
Adelaide Meath incorporating the National Children’s Hospital (AMNCH)
Tallaght, Dublin
Ireland.
Historical background

The evolution of day surgery has heralded a new era of medical, anaesthetic and nursing knowledge, skills and practice. Surgical techniques and technological advances coupled with developments in anaesthetic approaches have contributed positively and significantly not only to the initial but ongoing developments within the field of day surgery, which today accounts for 50–80% of all surgical procedures. The international drive to increase day surgery rates is grounded in the well articulated benefits including: reduced demand for overnight or weekend staff, hence reduced costs; more rapid throughput of patients; reduction in the number of patients on waiting lists and reduction in the number of patients who fail to attend for surgery.

Potential problems associated with surgery (post-operative nausea, vomiting or pain), responsibility for which may fall within a self-care remit or entail an increased burden on community services, require attention to ensure that day surgery services appropriately address these requirements. The political, economic and policy-driven demands for greater bed utilisation, value for money and cost containment measures have influenced the expansion and development of day surgery throughout its history.

The growth of day surgery, albeit a substantial one, is not a new concept. In the early stages of nursing, its founder, Florence Nightingale, noted that patients should not stay a day longer than is absolutely necessary in all hospitals and in particular children’s hospitals (Nightingale 1914). In recognising the significant value a shorter hospital stay has for the patient, her opinion was not based upon economic or political perspectives, but on
reducing the possibility of patients contracting further illness or diseases as a result of hospitalisation.

One of the earliest references to day surgery is that of the now landmark publication by Dr Nicoll in the *British Medical Journal* in 1909. Nicoll outlined his ten-year surgical experience of performing 8988 day surgery procedures at a Glasgow outpatients clinic for sick children. Over half of the children were less than three years old. The procedures included treatment of cleft palate, hare lip, hernias, talipes and mastoid diseases. Nicoll disapproved of hospitalisation and was adamant that children should return to their nursing mothers as early as possible. Even at this early stage of day surgery, he drew attention to the necessity for suitable home conditions in addition to General Practitioner (GP) support, a feature that was reiterated in 1955 by Farquharson.

In 1916 Ralph Waters wrote about his establishment of a free-standing anaesthesia clinic in Iowa, providing day surgery for dental and minor surgery cases. The revolution had begun. Hospital-based ambulatory units were developed in 1959 by Webb and Horace in Vancouver, in 1962 by Cohen and Dillon in Los Angeles and in 1970 by Levy and Coakley in Washington. The first successful free-standing ambulatory facility was established in 1969 by Ford and Reed in Arizona (Epstein 2005).

The day surgery revolution within the United Kingdom (UK) was slower to progress since first being mooted by Nicoll in 1909. It was not until over 50 years later, in 1960, that the first stand-alone day surgery unit within a hospital in the UK was developed at Hammersmith (Calnan and Martin 1971). In response to the evolution of day surgery, the Royal College of Surgeons in England published *Guidelines for Day Surgery* in 1985, based upon a working party report which stated that day surgery was the best possible option for 50% of all patients undergoing surgical procedures electively. At the time of the report the national average for day surgery was as low as 15%, despite Palumbo et al. (1952) outlining the possibility of greater bed utilisation owing to a shorter length of stay.

In 1989 the British Association of Day Surgery was established with a multidisciplinary membership, recognising the necessity for quality in the delivery of day surgery and the potential benefits, not only for patients but for the health service. Key drivers for day surgery within the UK were a number of pivotal reports published over a short period of time, which brought into intense focus the proliferation of day surgery units and facilities within the National Health Service (NHS). The first of these, the Bevan Report (1989), was undertaken by the NHS Management Executive Value for Money Unit. Support for day surgery expansion was indicated, given the significant impact it would have on waiting lists and financial costs. In 1990 the Audit Commission, an external auditor for the NHS, published *A Short Cut to Better Services*. This report is now recognised as one of the major catalysts for the development and advancement of day surgery within the UK. It examined the expansion of day surgery within England and
Wales, concluding that the rate of expansion was slower than anticipated; it also identified significant variances in day surgery between health authorities. A consequence of the report was the introduction of what became known as the ‘basket’ of 20 common procedures – still in use today – that could be performed as day surgery cases. The rationale for the introduction of this ‘basket’ of procedures was to develop uniformity and limit the variance in day surgery procedures across the health service, with a view to improving cost-effectiveness by increasing the number of patients that could be treated as day cases. The Audit Commission also reported on possible barriers to the growth of day surgery, such as lack of facilities, poor management structures and a preference for traditional approaches, and suggested methods to overcome them.

Building on the Audit Commission report, in 1991 the Value for Money Unit published *Day Surgery: Making it Happen*. This report focused on the design, practice and management of day units, outlined recommendations on staffing, training and quality, and highlighted the financial rewards for the NHS. Also in 1991 the Audit Commission reported on day surgery from the patient’s perspective: their investigation found that 80% of patients preferred day case surgery, with 83% recommending this approach to a friend. This report reinforced awareness of acceptance of day surgery by patients, thus justifying the continued expansion of this approach to surgery.

One of the motivating factors for the expansion of day surgery was clearly the resultant financial rewards for the NHS, although significant funding for the establishment of day surgery facilities would first be required. In recognition of the financial implications, a regional task force to oversee investment was established in the early 1990s. The task force produced a toolkit for managers and clinicians as an aid for the establishment and review of day surgery facilities, and set a target of 50% for all elective surgery as day case procedures. Despite significant investment, the report of the task force in 1993 revealed that few proposals had been implemented, with considerable variation in progress towards meeting the 50% target across the NHS, and raised the target to 75%. Not surprisingly, in 2001 the Audit Commission confirmed that no service was achieving 75%, with a number of units not being utilised to maximum capacity. Consequently, £31 million was invested from the Funding treasury Capital Modernisation in order to achieve the target of 75%. In conjunction with the launch of the Day Surgery Strategy in 2002, the *Day Surgery Operational Guide* was published in order to support the drive towards achieving the target of 75% and the Department of Health’s commitment to this strategy was evidenced by the inclusion of day surgery for inpatient stays as one of the NHS Modernisation Agency’s ‘10 High Impact Changes’.

By 2003 the Healthcare Commission was created and given the authority to take over responsibilities from other commissions, including the Audit Commission. In a review of the acute hospital day surgery portfolio in 2005, the Healthcare Commission reported that variability in the organisation of