DAY SURGERY IN AUSTRALIA

Report and Recommendations

of the

Australian Day Surgery Council

of

Royal Australasian College of Surgeons

Australian and New Zealand College of Anaesthetists

and

The Australian Society of Anaesthetists

REVISED EDITION 2004

Report and Recommendations on Day Surgery

REVISED EDITION 2004
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AUSTRALIAN DAY SURGERY COUNCIL

MISSION

"The Australian Day Surgery Council is a multi-disciplinary professional body advising on all matters pertaining to the high standards of quality and safety in Day Surgery practice".

VISION

"The Australian Day Surgery Council promotes best practice standards through a climate of continuous quality improvement and education."

VALUES

"The Australian Day Surgery Council values and promotes:
- Quality Day Surgery practice
- Professionalism and optimal patient care
- Multi-disciplinary education"

PRINCIPLE

The Council has not given exclusive support for facilities within existing hospitals or freestanding facilities but insists that the same standards apply to all.

Australian Day Surgery Council

Central Committee

Royal Australasian College of Surgeons

Australian & New Zealand College of Anaesthetists

Australian Society of Anaesthetists

Expanded Committee

Australian Association of Paediatric Surgeons

Australian Day Surgery Association

Australian Day Surgery Nurses Association

Australian Dental Association

Australian Hand Surgery Society

Australian Health Insurance Association

Australian Healthcare Association

Australian Medical Association

Australian Nursing Federation

Australian Orthopaedic Association

Australian Private Hospitals Association

Australian Society of Otolaryngology Head and Neck Surgery

Australian and New Zealand Association of Urological Surgeons

Australian Society of Plastic Surgeons

Gastroenterology Society of Australia

Interventional Radiology Society of Australia

Neurosurgical Society of Australasia

Royal Australian & New Zealand College of Obstetrics and Gynaecology

Royal Australian College of Ophthalmologists

The Australian Day Surgery Council was established by and is responsible to the founding members, Colleges and Associations currently represented by:

Australian and New Zealand College of Anaesthetists
"Ulimaroa", 630 St Kilda Road,
Melbourne, Vic. 3004
www.anzca.edu.au

Australian Society of Anaesthetists Ltd.
P O Box 600,
Edgecliff, NSW 2027
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Royal Australasian College of Surgeons
Spring Street, Melbourne, VIC. 3000
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Central Committee Members:

Royal Australasian College of Surgeons	Mr Randall Sach FRACS, Chairman Mr Hugh Bartholomeusz FRACS
Australian & New Zealand College of Anaesthetists	Dr Glenda Rudkin FANZCA, Secretary Dr Colleen Kane FANZCA
Australian Society of Anaesthetists	Dr Jennifer Parslow FANZCA Dr Elliott Rubinstein FANZCA

Extended Committee Members (2004):

Royal Australian College of Ophthalmologists	Mr Richard L Smith FRACS FRACO FRCS
Royal Australian & New Zealand College of Obstetrics & Gynaecology	Mr Richard Bellingham FRANZCOG, FRCOG

Organisation	Representative
Australian Dental Association (Oral & Maxillo-Facial Surgeon)	Mr Howard Sandler BDS, MScDent (WITS), Cert. in Oral & Maxillofacial Surgery (TUSTS, Boston)
Australian Society of Otolaryngology, Head & Neck Surgery	Mr Patrick Rundle FRACS
Gastroenterology Society of Australia	Dr Stephen J Williams FRACP
Interventional Radiology Society of Australia	Dr John E Clouston FRANZCR
Australian Orthopaedic Association	Professor Joe Ghabrial FRACS FRCS
Neurosurgical Society of Australasia	Mr William Sears FRACS
Australian Health Insurance Association	Mr Russell Schneider Wayne Adams
Australian Private Hospitals Association	Mr Mark Stephens FRACP
Australian Healthcare Association	Ms Joanne Fisher
Australian Association of Paediatric Surgeons	VACANT
Federal AMA	VACANT
Australian Hand Surgery Society	Mr Randall Sach FRACS
Australian Society of Plastic Surgeons	Mr Hugh Bartholomeusz FRACS
Australian Nursing Federation	Ms Michelle Birks
Australian Day Surgery Nurses Association	Ms Wendy Adams
Australian and New Zealand Association of Urological Surgeons	David Malouf FRACS
Australian Day Surgery Association	Ms Elizabeth Rankin BBus,GDip (Prof Acctg) FRAICD, MAIM

Representative to the Australian Council of Health Care Standards	Ms Celia Leary
Representatives to the International Association for Ambulatory Surgery:	Mr Hugh Bartholomeusz FRACS Mr Lindsay Roberts FRACS
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DAY SURGERY DEFINITIONS

- **Office or Outpatient Surgery/Procedure**
  An operation/procedure carried out in a medical practitioner's office or outpatient department, other than a service normally included in an attendance (consultation), which does not require treatment or observation in a Day Surgery/procedure centre (facility) or unit, or as a hospital in-patient.
- **Day Surgery/Procedure**
  An operation/procedure, excluding an office or outpatient operation/procedure, where the patient would normally be discharged on the same day.
- **Day Surgery/Procedure Patient**
  A patient having an operation/procedure, excluding an office or outpatient operation/ procedure, who is admitted and discharged on the same day.
- **Day Surgery Centre (Facility)**
  A registered centre (facility) designed for the optimum management of a Day Surgery/ procedure patient.
- **Day Surgery/Procedure - Extended Recovery Patient**
  A patient treated in a registered Day Surgery/procedure centre (facility) or unit, free standing or hospital based, who requires extended recovery including overnight stay, before discharge.
- **Extended Day Surgery/Procedure Recovery Centre/Unit**
  Purpose constructed/modified patient accommodation, free standing or within a registered Day Surgery centre (facility) or hospital, specifically designed for the extended recovery of Day Surgery/procedure patients and registered with Commonwealth/State Governments for this purpose.
- **Limited Care Accommodation**
  Hotel/hostel accommodation for Day Surgery/procedure patients where professional health care is available on a call basis.

History of Australian Day Surgery Council

In 1980, the initiative to create a Working Party on Day Surgery arose from the joint desire of the Royal Australasian College of Surgeons and the Australian Association of Surgeons to define acceptable standards of surgery and anaesthesia when performed in Day Surgery facilities. The Working Party at that time drew up an initial document of standards and then sought submissions from the following professional bodies:

- the nine specialty surgical boards of the RACS (for any special requirements of their disciplines)
- Royal Australian College of General Practitioners
- Royal Australian College of Ophthalmologists
- Australian Medical Association
- Australian Dental Association
- Ambulance Association of Victoria.

Most of the points made by these bodies were incorporated into the 1981 Report. The Report was then discussed in detail with representatives in the hospital, administration, and insurance fields, at a Conference on 19 September 1981, following the receipt of submissions by their appropriate bodies. These groups (and the individuals representing them) were as follows:

- Australian Medical Association (Professor R Webster)
- Royal Australian Nursing Federation (Miss J Cochrane)
- Australian Hospitals Association (Dr D Child, Mr E Pickering)
- National Standing Committee of Private Hospitals (Sr J Rohan, Mr A Hickling)
- Royal Australian College of Medical Administrators (Dr J Yeatman)
- Australian Council on Hospital Standards (Mr B Collopy)
- Voluntary Health Insurance Association of Australia (Mr L Mark)
- Council Australian Association of Surgeons and Council Royal Australasian College of Surgeons (Mr L Roberts)
- Mr B Morgan

In 1986 the Councils of the RACS and the AAS suggested re-convening the Working Party to revise the original Report, and the above bodies (with the exception of the Surgical Boards of the RACS) were again asked for submissions. Submissions were received from The Royal Australian College of Ophthalmologists, The Australian Medical Association, Mercy Hospital, Melbourne and Voluntary Health Insurance Associations of Australia, and these submissions were considered in revising this Report. Some other bodies were represented on the Working Party by their co-option. Mr B Collopy also represented the Australian Council on Hospital Standards.

In 1987 the Working Party was formalised as the Day Surgery Facility Professional Standards Advisory Committee, and in the following year, 1988, it was further changed to the National Day Surgery Committee.

During 1994-1995 the Committee identified Clinical Indicators for Day Surgery Centres (Facilities), and after a successful trial, they were introduced into the accreditation programme in January 1996.

In October 1996 the Committee changed its name to the **Australian Day Surgery Council**, thereby raising its status and providing greater authority to its activities.

In the period 1999-2001, at the request of the Royal Australasian College of Surgeons, guidelines for the accreditation of office-based surgery were developed by Randall Sach and Glenda Rudkin, with input from all members of the ADSC. These recommendations have subsequently been endorsed by the Council and adopted by other organizations.

In April 2001 Mr Lindsay Roberts, past Chairman of the Australian Day Surgery Council, was elected President of the International Association for Ambulatory Surgery.

A major strategic planning exercise was undertaken in 2002, allowing the Council better to define its role in contemporary Day Surgery practice.

Day Surgery Development in Australia

For many years, minor surgery has been carried out frequently in hospital casualty and surgical outpatient departments. In the last two decades, however, specialised units have been developed for surgical operations on patients who are not admitted to hospital overnight. Many articles have been written describing the structure and function of these Day Surgery facilities.

Day Surgery is now well established in Australia, both in public and private sectors. Currently, up to 60% of operative procedures are undertaken as day patient procedures. Day surgery is widely practiced in 240 free standing Day Surgery centres in Australia. In addition, Day Surgery is widely practiced in 320 private hospitals, and many large public hospitals have dedicated Day Surgery units in place.

In the USA up to 80% of operative procedures are carried out in Day Surgery facilities with the projected throughput to be 85% by the end of the decade.

A Day Surgery facility refers to a specific operating complex for the surgical treatment of patients who are admitted and discharged on the same day. The facility should be available to all members of the medical and dental professions who are suitably qualified and granted privileges to treat patients (as defined below).

The reduction in cost to both the patient and the community, coupled with the advantages of Day Surgery for both patients and their relatives, have served to increase the demand for Day Surgery.

1. Economic advantages:

The philosophy, mechanisms and costs of medical services and facilities continue to be critically examined. Day Surgery allows the treatment of large numbers of patients at less cost than in-patient surgical treatment for the same conditions. Costs are reduced because:

(i) staff and facilities are predominantly not needed at night, at weekends or on public holidays;

(ii) fewer staff are required for a Day Surgery facility than for comparable in-patient surgery;

(iii) if an operation suitable for Day Surgery is carried out as an in-patient, expensive hospital beds are occupied, thereby using up more capital equipment, patient and administrative time;

(iv) the use of a Day Surgery facility reduces the number of in-patient beds required;

2. Advantages to hospitals:

These are:

(i) the economic savings detailed above;

(ii) more attractive to nursing staff because there is less shift work involved;

(iii) in-patient facilities can be run more efficiently if there are fewer day patients. The preparation of records, the examination and preparation of patients for operation, post-operative care, and the discharge of Day Surgery patients may divert staff from the care of in-patients with major illnesses.

3. Advantages to patients and their relatives:

These include:

(i) a considerable reduction in the risk of cross-infection when compared with patients who remain in hospital;

(ii) a reduction in the risk of thrombo-embolism associated with early ambulation;

(iii) less anxiety for the patient when an overnight stay in hospital is avoided, particularly in the case of children who are separated from their parents for as short a time as possible, and for older patients who are more prone to disorientation when removed from their familiar surroundings for extended periods of time;

(iv) a quicker return to normal activities with less time off work;

(v) less stress for relatives of patients, and a savings in time, travel, and sometimes in accommodation needed to visit an in-patient in hospital.

Office Based Surgery Development in Australia

Guidelines for the accreditation of office based surgery facilities

It has been traditional for minor operations and many diagnostic procedures to be carried out under local anaesthesia or without anaesthesia in medical practitioners' consulting rooms, specialists and general. In recent years, some of these operations/procedures have been carried out under sedation, intravenous or intramuscular.

Very few medical practitioners have a separate office based surgery unit, and they are not formally recognised by government or health insurers. The absence of a facility rebate for office based surgery units is a major disincentive for medical practitioners to carry out minor operations/procedures as office based services.

It is important that the same standards of quality and safety be provided for patients having office based operations/procedures as apply at hospitals and Day Surgery centres.

In 1999, the Australian Day Surgery Council was requested to prepare guidelines for office based surgery which might form the basis for an accreditation process applying to these units. At a meeting of Council on 30th October 1999, Guidelines for the Accreditation of Office Based Surgery were adopted.

The guidelines incorporate:

Part 1. Procedures performed under local anaesthesia alone.
Part 2. Procedures performed under local anaesthesia and sedation.

Refer to Appendix D.

The accreditation of office based surgery units would be the responsibility of recognised accreditation organizations, and these Guidelines might assist in the development of an accreditation process appropriate for office based surgery.

Council does not consider that an accreditation process should be compulsory, preferring that it be optional for those medical practitioners who provide a separate, appropriately equipped unit for these operations/procedures.

It is emphasised that the choice of patient, operation/procedure, and type of anaesthetic/sedation must remain the responsibility of the surgeon and or/anaesthetist.

Principles for Day Surgery in Australia

The Australian Day Surgery Council was established to draw up standards and guidelines for staffing and equipping centres for Day Surgery, and has agreed to the following points of principle:

1. Day Surgery facilities should provide cost-effective and safe methods of treatment for a range of surgical procedures. This involves a number of advantages for both patient, hospital and community.

2. Wherever such Day Surgery facilities exist, certain minimal standards for professional staffing and the provision of equipment must be met before they can be approved and registered. The standards of patient care offered at administrative, clinical and technical levels must be the same as those provided in in-patient accommodation. Accreditation bodies have been established to assist in regulation of standards for Day Surgery practice.

3. The Council has formulated detailed standards and guidelines which are supported by the Councils of the Royal Australasian College of Surgeons, the Australian and New Zealand College of Anaesthetists, and by the Australian Society of Anaesthetists, and thus are available for the guidance of other organisations. These standards are set out in Appendices A, B, C and D.

4. To administer the facilities and afford proper mechanisms for accreditation and control, there will need to be:
   (i) a federal representative committee responsible for establishing standards; the Australian Day Surgery Council is responsible for meeting this requirement.
   (ii) a professional group responsible for regulating and accrediting individual centres; specific accreditation bodies have been developed for this purpose.
   (iii) a Medical Executive Committee in each Day Surgery facility to manage and monitor its performance and ensure the observance of standards. These administrative arrangements are set out in Appendix E.

5. The development of Day Surgery facilities needs to be integrated into the health services planned for the community. Proper planning and disposition of such centres, together with adequate mechanisms of accreditation and peer review of medical staff, will assist in limiting the opportunity for over-utilisation of services or of performing inappropriate surgery.

6. Council fully supports and encourages a pre-operative assessment process for all Day Surgery patients. This assessment should address the medical, nursing, social, educational, financial and discharge requirements of the patient.

7. Appropriately selected patients with acute surgical problems, including trauma, may be treated in day surgery centres/units, freestanding or hospital based, provided there is no compromise to clinical, administrative or discharge standards.

8. Integrated systems need to be in place for adequate pre-assessment (nursing and anaesthestic). Occupational health and safety, infection control and quality systems need to be in place in all Day Surgery facilities. See Appendix C.

   Supervised after care of all patients in their home environment or at a registered step down facility needs to occur.

9. Day Surgery facilities should encourage provision for the teaching of undergraduate and postgraduate medical and nursing staff.

   The Council recommends that surveys for the accreditation of Day Surgery facilities be based on a manual for the accreditation of these facilities. Specific organisations should be responsible for the accreditation of Day Surgery facilities.

   These administrative standards are set out in Appendix E.

Guidelines and Standards for Day Surgery in Australia

1. Existing hospitals vs. freestanding facilities

Day Surgery facilities can be organised in a number of ways.

(a) a hospital (public or private) may establish a Day Surgery facility in parallel with in-patient services using existing admitting areas, wards, operating theatres and recovery rooms;

(b) a hospital (public or private) may establish a Day Surgery facility within the hospital, sharing the theatre and recovery areas, but with separate admission and ward areas;

(c) a purpose built facility within an existing public or private hospital with its own admission, theatre, recovery and discharge areas;

(d) a Day Surgery facility may be freestanding and purpose built. It may be managed by an existing hospital or operated independently.

The Council felt that local conditions might determine the optimum arrangement for a particular area, but certain guidelines can be stated:

1.1 Day Surgery facilities within hospitals should preferably have their own admission and discharge areas and patient rest facilities quite independent of those applying to in-patient services.

Arrangement (a) above is therefore not generally recommended. Separate facilities are essential to simplify admission and discharge, to reduce unnecessary delays, to benefit from the staffing efficiencies identified in the preamble, and to use rooms and administration specially designed for Day Surgery. The standards applying to these Day Surgery facilities should apply equally to the hospital itself.

1.2 The operating theatres used by the Day Surgery facility must have the same standards as those applying to in-patient services with regard to size, lighting, ventilation, equipment and quality of staff (including anaesthetic and theatre technician staff).

There is no such thing as a minor anaesthetic, and any anaesthetic or surgical procedure may develop unforeseen major complications. Standards demand that facilities must be immediately available for such complications.

1.3 Equally, the operating theatres of the Day Surgery facility must be backed by a fully-equipped post-operative recovery ward and readily available anaesthetic staff. Standards for anaesthetic management and facilities, including assessment and recovery are set out in Appendix C. These facilities are readily available when the

facility is created within a hospital with an available pool of anaesthetists. A freestanding Day Surgery facility will require the same standards.

1.4 An essential requirement of a freestanding Day Surgery facility is a written agreement for transfer of a patient to an in-patient bed of a public or private hospital, should they be deemed unfit for discharge from the Day Surgery facility. Adequate safe means for the transfer of a patient must be available.

1.5 Freestanding and independently operated facilities offer some advantages over traditional in-patient care and integrated Day Surgery facilities. These include:
i. a streamlined approach to the surgical episode;
ii. costs can be more easily identified and controlled;
iii. the risk of nosocomial infections are reduced.
iv. integrated total patient care can be better provided where there is dedicated and well trained Day Surgery staff.

However, the establishment costs of the provision of high quality technical equipment may not be cost effective for some specialized procedures in smaller free standing Day Surgery facilities.

2. Surgical and anaesthetic requirements

These are set down in detail in the Appendices, but certain guidelines are appropriate.

2.1 Day Surgery facilities will be available for use by all members of the medical and dental professions appropriately accredited to that facility. Both the Council of the Royal Australasian College of Surgeons and the Federal Council of the Australian Association of Surgeons believe that, except in certain circumstances, such as an experienced general practitioner or experienced dental practitioner granted privileges to treat patients, the necessary qualification for the surgeon to be accredited is that he/she possess a higher surgical qualification registerable in Australia; for the anaesthetist, as defined in the ANZCA document `Privileges in Anaesthesia' (Appendix C); and for specialist Oral and Maxillofacial procedures, the dental practitioner should possess a higher qualification applicable to Oral Surgery or a Specialist Registration in that discipline. Professional expertise is essential to minimise complications, to make correct judgements about the suitability of patients, and to have competence to deal with major complications should they occur.

2.2 Patients presenting for treatment in a Day Surgery facility under general anaesthesia must be essentially healthy people with good home support available in the first 12-24 hours post-surgery. The term `healthy' is mainly in respect to the cardio-respiratory systems and need not necessarily exclude patients who are not

ambulatory for other reasons, especially for procedures performed under local or regional block anaesthesia. Guidelines of suitability are more specifically set out in Appendix B. The assessment of recovery from anaesthesia and fitness for discharge are the responsibilities of the anaesthetist and the surgeon. They must arrange admission to an appropriate hospital bed if the patient is judged unfit for discharge. Reference should be made to the ANZCA document `Guidelines for the Care of Patients Recovering from Anaesthesia Related to Day Surgery' (Addendum 5).

The Australian Day Surgery Nurses Association (ADSNA) has also prepared nursing guidelines, refer Appendix G.

2.3 It should be the responsibility of the Day Surgery facility governing body to maintain the physical facility, equipment and the appropriate staff to the standards set out in this report. There should be a Medical Executive Committee in each Day Surgery facility to advise the governing body on management and monitoring its performance and ensuring the observance of standards.

2.4 The selection of patients is a professional decision and will vary depending on the surgeon's judgement, the assessment of the patient, and the standard of the facility and its back-up services. Guidelines of suitability are detailed in Appendix B.

2.5 Before operation the procedure must be explained to the patient (and/or parents), informed medical and financial consent obtained, and written instructions must be given to the patient (and/or parents) for admission. Requirements for fasting, arrangements for transport to and from the facility etc, are set out in Appendices B, C and D.

2.6 Admission to the facility should be direct to the facility and independent of other hospital admissions.

2.7 After operation/procedure, all patients should be transferred to a recovery room. The duration of stay will vary, dependent upon the anaesthetic type provided, medical fitness of the patient and the availability of the patient escort. Patients must fulfill appropriate discharge criteria before discharge.

2.8 Discharge arrangements are the responsibility of the anaesthetist and the surgeon (though may be determined by the nurse in conjunction with appropriate protocols and criteria) and should include the supply of appropriate drugs and dressings, written post-operative instructions including medical care, warnings about driving,

transport, work, alcohol intake, whom to contact if problems arise and a post-operative appointment - see Appendices B and D.

Post anaesthesia, both physical and mental capacity may be impaired for some time, thus affecting an individual's ability to drive. This is applicable to both general and local anaesthesia. The effects of general anaesthesia will depend on factors such as the duration of anaesthesia, the drugs administered and the surgery performed. The degree of effect of local anaesthesia on driving ability is dependent on dosage and region of administration. A further factor to consider is the effects of analgesics and sedatives. In cases of post-operative recovery following surgery, or procedures under general or local anaesthesia, it is the responsibility of the surgeon and anaesthetist to advise patients not to drive until physical and mental recovery is compatible with safe driving. Following minor procedures under local anaesthesia without sedation (eg dental block), driving may be acceptable immediately following the procedure. Following brief surgery or procedures with short acting anaesthetic drugs, the patient may be fit to drive after a normal night's sleep. After longer surgery or procedures requiring long-acting anaesthesia, it may not be safe to drive for 24 hours or more.

3. Ward area and staffing

These are matters of detail and are set out in Appendix A.

4. Theatre and recovery area

Theatre and recovery areas as detailed in Appendix A are subject to the approval of local licensing health authorities.

5. Hours of operation

The Council made no specific recommendation about ideal operating times, as this will depend on local conditions and the volume load of patients.

6. Records

- It was agreed that a medical record be established for all patients treated in Day Surgery facilities and this record should satisfy the minimum standards of records for accreditation. Patients' records should be simple and brief and should contain:
- a request and consent form for operation and anaesthetic;
- a basic medical history and examination;
- a day case pre-operation checklist;
- an operation and anaesthetic record;
- a recovery room and day case centre report (including a record of untoward events); post-operative orders and fulfillment of discharge criteria;

7. Registration, accreditation and control

In order to ensure that standards of care are maintained, the Council recommends that Day Surgery facilities be accredited by an appropriate organisation.

The standards as set out in this report have been communicated to the Australian accreditation organizations to be included in their publications.

To administer the facilities and afford proper mechanisms for accreditation and control, it is envisaged that there will need to be:

a. a federal representative committee responsible for establishing standards; (the ADSC fulfills this requirement)
b. a professional organization responsible for accrediting individual facilities.
c. a medical executive committee in each Day Surgery facility to manage and monitor its performance and ensure the observance of standards.

These administrative arrangements are set out in Appendix E.

Expanding Day Surgery Care

The Australian Day Surgery Council has produced guidelines for:

1. Extended recovery in Day Surgery centres
2. Limited care accommodation

These are:

1. Extended Day Surgery/Procedure Recovery Centre/Unit.

Definition

- Purpose constructed/modified patient accommodation, within a registered Day Surgery centre or hospital, specifically designed for the extended recovery of Day Surgery/procedure patients, and registered with the Commonwealth Government for this purpose.

1.1 Location

- Extension of the Recovery area of the Day Surgery centre (facility). Separate rooms may be provided.

1.2 General Services

All services as per the usual Day Surgery centre (facility).

Patients may be nursed on trolleys or transferred to beds. Call bells available.

1.3 Meals

- Centres (facilities) should meet the needs of the patients and be run in accordance with local food handling regulations.

1.4 Medical/Nursing Services

- Minimum of two Registered Nurses and/or other appropriately qualified personnel as per legislation present at all times.
- Nurse/patient ratios will depend on the acuity of the patients, but should not exceed 1:5.
- The surgeon, the anaesthetist or a designated medical practitioner must be contactable at all times, and able to attend the centre (facility) if needed.
- All emergency equipment and procedures should be in place as per usual Day Surgery centre (facility).
- Clinical protocols should be in place for channelling and selecting patients for this service. Extended recovery may be planned or unplanned.
  Planned: Patients purpose booked for extended recovery.
  Unplanned: Patients selected for extended recovery as clinically indicated after admission to the Day Surgery centre/unit.
- Discharge protocols should be in place, and should include nurse initiated discharge protocol.
- Special arrangements must be in place for:
  Transferring patients to an acute care facility
  Emergency codes overnight

1.5 Security

- Arrangements must be made to secure the building at night.
  For example a security firm visiting regularly; or
  Duress alarms linked to security firm/police.

2. Limited Care Accommodation Facilities

Adopted by ADSC in 2001

Definition

Hotel/hostel accommodation for Day Surgery/procedure patients where professional health care is available on a call basis.

It is the responsibility of the attending medical practitioner to refer appropriate patients to a limited care Accommodation Facility.

2.1 Location

(a) Free Standing Facility

Connected to a Day Surgery Centre

Separate, stand alone facility to which Day Surgery patients are regularly transferred, with ground floor access or lift/ramp access.

(b) Hospital Located Facility – public or private

Separate or connected free standing facility on the campus of a hospital

Dedicated section of a hospital

2.2 General Services

- Administration Office
- Store room e.g. linen, records etc.
- Cleaners room/service
- Linen/laundry service
- Contract for dispersal of contaminated waste and linen.

Note: Some or all of the above would not be essential for facilities located within a hospital or attached to a free standing Day Surgery centre.

2.3 Accommodation

- Each unit (room) would provide the following:-
- Patient bed (or cot)
- One extra bed for partner/carer
- One comfortable lounge chair
- En-suite with shower, basin and toilet
- Simple cupboard and drawers
- Air-conditioning/heating
- Tea/coffee, toast making equipment
- Refrigerator
- Television
- Telephone
- Wheelchair accessibility

2.4 Lounge

A comfortable lounge room for patients and relatives/carers, including a suitable separate area for children and parents.

2.5 Meals/Dining

- Free Standing Facilities

Meals would be provided by one of the following options:

- External catering by private contract
- Kitchen within the facility providing room service
- Kitchen/dining room within the facility

Note: Each unit would provide simple food preparation equipment for light meals/snacks with hot and cold beverages.

- Integrated accommodation within a hospital
  Meals would be provided by the hospital catering service
  Note: In free-standing facilities a combined lounge/dining area might be provided.

2.6 Medical/Nursing Services

A limited care accommodation facility must provide the following:

- A limited care accommodation facility must provide an immediately available manager/attendant who may be a nurse or a person trained in cardio-pulmonary resuscitation.
- An emergency 24 hours call system in each room.
  - The emergency call system would be linked to the hospital or Day Surgery nurse emergency call system where the limited care accommodation is located within an acute bed hospital or attached to a free standing Day Surgery centre with extended recovery services, which includes on-site 24 hour nursing service.
  - The emergency call system would be connected to the office of the on-site manager/attendant, who may be a nurse or a person trained in cardio-pulmonary resuscitation, where the limited care accommodation facility is either a separate stand alone facility or is attached to a same day free standing Day Surgery centre.
- An emergency cardio-pulmonary resuscitation trolley equipped to the Australian and New Zealand College of Anaesthetist Standards with an extra self-inflating bag suitable for artificial ventilation for every 10 rooms).
- An appropriately equipped medical utility room with hand wash basin and disposal container for sharps and contaminated dressings etc. for the use of medical practitioners and nurses, including infection control guidelines.
- A telephone in each room and on-site manager/attendant office for contact with the attending surgeon, anaesthetist, general practitioner and ambulance.
- There must be an arrangement for the transfer of patients to an acute care facility for the on-going treatment of a medical emergency.

2.7 Medication

Patients' medication is the responsibility of the patient or relative/carer.

2.8 Records

Records to be maintained including patients, resident relative/carer, attending medical practitioner, time and date of admission – discharge and details of any patient incidents.

Open Access Endoscopy

Patients who attend open access endoscopy units should be provided with the information pertaining to the risk of the procedure they are to undergo **before** they make a booking to have that procedure performed. In particular they should be provided with the information well before they have taken any bowel preparation. It is considered that a patient who is provided with a risk profile for their procedure after they have taken the bowel preparation may to some degree have been coerced by being prepared.

It is also considered that a doctor who refers a patient to an open access endoscopy centre has a duty of care to provide information about the rare but possible complications of the procedure at the time of referral. In most cases this is a general practitioner. It is therefore beholden to the manager of an open access endoscopy facility to ensure that the doctors who refer to that facility are informed of the risks of the procedures so that they can provide their patients with accurate information.

APPENDIX A

THE PHYSICAL FACILITIES AND STAFFING OF DAY SURGERY FACILITIES

The physical facility

The complete facility should allow for:

1. an admission and reception area (including interview room);
2. pre- and post-operative holding area;
3. Director of Nursing office and nurse station;
4. clean (sterilizing) and dirty utility rooms;
5. adequate store room;
6. toilets (including disabled) and showering facilities
7. facilities for refreshment for patients
8. theatre and recovery area;
9. a discharge area;
10. medical records;
11. x-ray facilities if required
12. pathology collection area as necessary
13. staff tea room
14. staff change room
15. emergency ambulance pick-up area
16. conference/teaching room for facilities involved with teaching

1. Admission and reception area

    1.1 It should be separate from the in-patient admission area.
    1.2 It should be located next to the patient holding area.
    1.3 There should be direct and easy access for patients from the hospital entrance with adequate signposting etc.
    1.4 The area requires.
        1.4.1 a clerical area (including a private interview area) for the secretary/ receptionist containing normal office equipment. Its function is the reception of patients, the establishment of the medical records, the secretarial aspects of pre-admission and discharge letters and the keeping of a surgical audit of statistics and clinical material;
        1.4.2 a lounge area for patients and relatives, including a children's play area as necessary

2. Pre- and post-operative holding area

   2.1 It should be located next to the admission and discharge areas and to the theatre.
   2.2 Size and local architecture will determine whether the area should consist of single cubicles or single rooms or a ward with suitable screens. The essential requirements are:
      2.2.1 privacy for the patient to dress and undress;
      2.2.2 the patient must be visible to the nursing staff, or have access to a patient bell at all times;
      2.2.3 large enough for undressing and dressing and containing facilities for secure storage of clothes and a mirror;
      2.2.4 chairs for relatives and for the patient to sit in before discharge;
      2.2.5 in facilities catering for children, consideration needs to be given to colour, decoration, size of beds and furniture etc.

   With proper design ensuring privacy, the area can be mixed male and female.

3. Registered Nurse's office and nursing station

   3.1 It must ensure visibility of all patients where possible and have patient call bells within visual range of station;

   3.2 It may include suitable benches and cupboards for the storage of medical records which should be ergonomically designed to meet the needs of the facility.

4. Utility rooms

These should include sterile store, general store, linen bay and dirty utility.

5. Storeroom/Cupboard

This is required for bed linen, for patients' gowns and dressing gowns, for trolleys and other theatre equipment not in use, and for disposables such as sanitary towels, paper towels and stationery.

6. Toilet facilities including disabled access

7. Refreshments

It is not anticipated that full meals will be available in Day Surgery facilities but both patients and relatives should be offered a simple cup of tea or coffee and light refreshments.

8. Theatre and recovery room

8.1 The operating theatre used for day patients must have the same standards as those applying to in-patient services - with regard to size, lighting, ventilation, equipment and quality of staff, including anaesthetic and theatre technician staff.

8.2 The recovery area must be closely associated with the theatre complex and be as fully equipped as a recovery area applicable to post-operative in-patients (see Appendix C).

8.3 Local arrangements will determine whether the theatre for day patients is a separate facility or one of the normal in-patient theatres; whatever the arrangement, there must be a full and immediate access to a recovery area and anaesthetic staff.

8.4 A notice board area with clear instructions indicating the storage site of emergency equipment such as cardiac arrest board, intubation apparatus, suction tubes etc. (see Anaesthetic Recommendations).

9. Discharge area

9.1 It should be close to the ward/recovery area so that surgical, anaesthetic, nursing and clerical staff can co-ordinate arrangements.

9.2 The discharge area should be designed to have easy access to vehicles, including ambulances and wheelchairs, to minimise walking for the post-operative patient and to facilitate transfer to another hospital if required.

10. Medical records

These are discussed in Appendix D.

11. X-Ray and pathology services

These services should be available for Day Surgery patients if the surgery being performed necessitates such services.

12. Staff change-rooms

If the Day Surgery facility is freestanding, or is a separate entity within a hospital, staff change-rooms for both theatre and non-theatre staff will be required, including associated toilets and secure storage lockers.

13. Parking

Adequate parking both for staff and for relatives who will deliver and take home patients is essential. A dedicated area for pick-up and set-down of patients must be provided and a parking bay sign posted as ambulance only must be available.

Staffing

1. Nursing staff

   Staffing is dependent upon:
   1. Availability of preassessment clinic
   2. Design of facility
   3. Patient turnover
   4. Patient fitness and procedures
   5. Skills and competency of staff

2. Clerical staff

Administration Manager and associated administration staff as necessary for the efficient functioning of the Day Surgery Unit, including clerking and billing of all patient episodes and submission of statutory data to health authorities.

3. Ancillary Staff (cleaning, catering etc.)

As appropriate to facility needs.

Equipment and biomedical and building safety and maintenance

Equipment used for the provision of care to patients for either direct care or indirect care should be in safe working order and compliant to Australian safety standards.

A documented national standard, such as NATA should be referred to for the calibration and testing as well as the electrical safety validation of Biomedical equipment used in the process of direct patient care according to the manufacturer's recommendations.

Provisional improvement notices should be given where patient care is substandard and/or biomedical equipment is in some disrepair, and it is obvious that this is affecting patient care, services, infection control and safety for patients, staff and visitors.

Significant financial fines for failure to repair should be the only penalty when the repair is not achieved in a reasonable timeframe.

Refer to appropriate Australian Standards.

APPENDIX B

SURGICAL STANDARDS AND PROCEDURES FOR DAY SURGERY FACILITIES

1. The surgeon must be accredited and the requirement for accreditation is the possession of a higher surgical qualification registerable in Australia.

2. It shall be the responsibility of the surgeon and/or his anaesthetist, to select those patients suitable for treatment as Day Surgery patients with maximum regard for safety and the maintenance of the highest professional standards. In the event that any patient is considered not fit for discharge following an operation, then the attending medical practitioner shall be notified and be responsible for the patient's transfer to an appropriate public or private hospital for further management.

3. It shall be the responsibility of the Day Surgery facility governing body to maintain the physical plant and equipment and the appropriate staff to the standards set out in this report. There should be a Medical Executive Committee in each Day Surgery facility to determine and advise the governing body in the management and monitoring of its performance and ensuring the observance of standards. Monitoring of performance should include the follow-up of outcome of treatment.

4. To assist the Medical Executive Committee with a criterion for the assessment of credentials the Council considers that any surgeon, dentist or anaesthetist appointed as a Visiting Medical Officer to a public hospital or who has been granted privileges at a major private hospital, should normally be granted privileges at a Day Surgery facility.

5. The final decision about fitness for anaesthesia rests with the anaesthetist who is to administer the anaesthetic. Suggested criteria are outlined in Appendix C.

Guidelines on the suitability of patients are:

1. an assessment that post-operative pain and nausea and vomiting can be controlled;
2. an assessment that the post-operative course is predictable;
3. a willingness on the part of the patient to be so treated;
4. provision of transport by a person other than the patient and availability of a suitable person at home to support the patient;
5. no language difficulty for the communication of instructions;
6. exclusion of patients who do not satisfy the categories as defined above.

7. The pre-operative preparation by the surgeon must include an explanation of the procedure, the reasons for it and the expected result.
8 Clear mechanisms must be established for the notification of pre-admission arrangements by the facility, as outlined in Appendix D. In the case of children, a pre-admission visit to the centre may be helpful to reduce anxiety.
9. After admission to the facility, the patient is clinically admitted and prepared for theatre, inclusive of specific pre-operative preparations for their procedure. Admission instructions should advise that no responsibility is taken for the care of valuables, although a storage area should be provided.
10. Patients should be advised not to leave valuables behind when going to theatre.

Discharge Arrangements

- Refer to Appendix C (Anaesthetic Standards in Day Surgery Facilities) Item 7 – Discharge of patient from Day Surgery unit

- Refer also to Australian Day Surgery Nurses Association (ADSNA) Guidelines

APPENDIX C
ANAESTHETIC STANDARDS IN DAY SURGERY FACILITIES

1. General comment.
2. The anaesthetist.
3. Selection Guidelines
4. Patient Preparation
5. Anaesthesia
6. Recovery from anaesthesia
7. Discharge of the Patient from the Day care Unit
8. Fitness to drive after anaesthesia
9. Quality Assurance
10. Addenda

1. General comment

Day Surgery demands a special expertise of the anaesthetist. The challenge is to select a suitable patient, recognizing and evaluating risk and possible complications for both the surgical procedure and the individual patient. Individual assessment is made when the potential patient's suitability is evaluated and investigations carried out according to clinical need. The anaesthetist must provide adequate anaesthesia for the surgery to be performed in an unpremedicated patient, with the patient being fit to be discharged from the facility on the day of surgery. Anaesthesia for the procedure may require general, regional or local anaesthesia, sedative techniques or a combination of techniques.

2. The anaesthetist

2.1 The anaesthetist must be accredited, and the standard for accreditation will be the Diploma of Fellowship of the Australian and New Zealand College of Anaesthetists (FANZCA). Alternatively, accreditation may be given to anaesthetists who have been assessed and supported as specialists by the College (Policy document PS16) or accredited by the Joint Consultative Committee of Anaesthesia (JCCA), in partnership with the Royal Australian College of General Practitioners (RACGP) and The Australian College of Rural and Remote Medicine (ACRRM). Refer ANZCA Policy Document PS1

3. Selection Guidelines (From Policy Document PS15)

In all cases, the ultimate decision as to the suitability of a patient for Day Surgery is that of the procedural anaesthetist. The decision as to the type of anaesthesia must remain in the province of the anaesthetist and will be based on surgical requirements, patient considerations, the experience of the anaesthetist and the facilities of the Day Surgery unit. Refer ANZCA Policy Document PS15.

3.1 Procedures suitable for Day Surgery must entail:

3.1.1 A minimal risk of post operative haemorrhage.

3.1.2 A minimal risk of post operative airway compromise.

3.1.3 Post operative pain controllable by outpatient management techniques.

3.1.4 No special post operative nursing requirements that cannot be met by hospital in the home or district nurse facilities.

3.1.5 A rapid return to normal fluid and food intake.

3.1.6 Early commencement of procedures for which a long recovery period is likely.

3.2 Patient requirements for Day Surgery include:

3.2.1 A willingness to have the procedure performed, together with an understanding of the process and an ability to follow discharge instructions.

3.2.2 The patient's place of residence for post-surgery care being within one hour's travelling time from appropriate post-operative medical attention.

3.2.3 Physical status of ASA I or II. Medically stable ASA III or IV patients may be accepted for Day Surgery following consultation with the anaesthetist concerned.

3.2.4 American Society of Anesthesiologists Classification of Physical Status for Pre-Operative Assessment.

CLASS 1: There is no organic, physiological, biochemical or psychiatric disturbance; the pathological process for which operation is to be performed is localised and not conducive to systemic disturbance.

CLASS 2: Mild to moderate systemic disturbance caused by either the condition to be treated surgically, or by other pathophysiological processes.

CLASS 3: Severe systemic disturbance or pathology from whatever cause.

CLASS 4: A patient with a severe life-threatening systemic disorder which may not be corrected by the operation.

CLASS 5: A moribund patient with little chance of survival.

EMERGENCY OPERATION: Any patient who is operated on as an emergency is considered to be in somewhat poorer condition. The letter `E' is placed beside the numerical classification, but the classification is not changed in grade.

3.2.5 Normal term infants of over six weeks of age or ex-premature infants (less than 37 weeks gestation) of more than 52 weeks post-conceptual age. Younger children may be accepted in units with particular paediatric experience after prior consultation with the involved anaesthetist. Longer post-operative observation may be necessary

3.3. Social requirements for Day Surgery include:

3.3.1 A responsible person able to transport the patient home in a suitable vehicle. A train or bus is usually not suitable.

3.3.2 A responsible person staying at least overnight following discharge from the unit. This person must be physically and mentally able to make decisions for the patient's welfare when necessary.

3.3.3 Ensuring that the patient and/or responsible person understands the requirements for post anaesthetic care and intends to comply with these requirements particularly with regard to public safety.

3.3.4 The patient remaining within one hour of appropriate medical attention until the morning following discharge.

3.3.5 The patient having ready access to a telephone in the post-operative dwelling.

3.3.6 The patient having advice as to when to resume activities such as driving and decision making.

4. Patient Preparation

4.1 Consultation by an anaesthetist is essential for the medical assessment of a patient prior to anaesthesia in order to ensure that the patient is in an optimal state of health, that the anaesthesia management can be planned, and the patient appropriately informed of the anaesthesia and related procedures. A written summary of the assessment, including those risks and potential complications discussed, should be documented in the medical record.

4.2 Patients and/or their relatives are entitled to know the implications of anaesthesia, sedation or other treatment before it is administered and to seek clarification of any issues which may be of concern. They must be free to accept or reject advice. Refer ANZCA Policy document PS26

4.3 Patient assessment can be assisted by:

4.3.1 A standardised patient health/anaesthesia questionnaire.

4.3.2 Prior referral of the patient by the surgeon to the anaesthetist in cases of doubt as to the suitability for Day Surgery.

4.3.3 Preliminary nurse assessment according to guidelines approved by an anaesthetist.

4.3.4 Anaesthesia consultation and preparation prior to the day of surgery preferably by the involved anaesthetist

4.4 The patient should be provided with information in an understandable written format which must include:

4.4.1 General information about the procedures to be followed in the day care unit.

4.4.2 Instructions for fasting according to the following guidelines, unless otherwise specifically prescribed by the anaesthetist or where other institution guidelines apply:

4.4.2.1 Limited solid food may be taken up to six hours prior to anaesthesia.

4.4.2.2 Unsweetened clear fluids totalling not more than 200 ml per hour in adults may be taken up to two hours prior to anaesthesia. Body fluid depletion due to excessive fasting should be avoided.

4.4.2.3 For infants, breast milk may be given up to four hours prior to anaesthesia.

4.4.2.4 Only medications or water ordered by the anaesthetist should be taken less than three hours prior to anaesthesia.

4.4.2.5 An H2-receptor antagonist should be considered for patients with an increased risk of gastric regurgitation.

4.4.3 A discharge planning questionnaire
Refer ANZCA Policy Document PS15

5. Anaesthesia

5.1 The provision of safe anaesthesia in hospitals requires appropriate staff, facilities and equipment.

6. Recovery from Anaesthesia

6.1 A well-planned, well-equipped, well-staffed and well-managed post-anaesthesia recovery area is essential for the safe early management of patients who have recently undergone a surgical or other procedure, irrespective of the type of anaesthesia or sedation used. Refer ANZCA Policy document PS4.

6.2 An area must be provided with comfortable reclining seating for patients during the second stage of recovery prior to discharge home. This area must be adequately supervised by nursing staff and should also have ready access to resuscitation equipment, including oxygen and suction. Patients must not leave this area unaccompanied.

7. Discharge of the Patient from the Day Surgery Unit

The discharge area should have ready access to wheel chairs, a parking area and ambulance facilities so as to minimise walking for the post-operative patient and to aid transfer of the patient to inpatient hospital care when this is necessary.

The following criteria apply to patients being discharged home:

7.1 Stable vital signs for at least one hour.
7.2 Correct orientation as to time, place and relevant people.
7.3 Adequate pain control.
7.4 Minimal nausea, vomiting or dizziness.
7.5 Adequate hydration and likelihood of maintenance with oral fluids.
7.6 Minimal bleeding or wound drainage.
7.7 Patients at significant risk of urinary retention (central neural blockade, pelvic and other surgery) must have passed urine.
7.8 A responsible adult to take the patient home. For some patients it may be important to have an adult escort, in addition to the vehicle driver.
7.9 Discharge should be authorised by an appropriate staff member after discharge criteria have been satisfied.
7.10 Written and verbal instructions for all relevant aspects of post-anaesthetic and surgical care must be given to the patient and the accompanying adult. A contact place and telephone number for emergency medical care must be included.
7.11 Suitable analgesia should be provided for at least the first day after discharge with clear written instructions on how and when it should be used. Advice on any other regular medication is also necessary.
7.12 A telephone enquiry as to the patient's wellbeing on the following day should be made whenever possible.

If the patient is to be transferred to an inpatient facility, the anaesthetist and/or the surgeon will be responsible for the patient until care has been transferred to another appropriate medical officer.

8. Fitness to drive after anaesthesia

Post anaesthesia, both physical and mental capacity may be impaired for some time, thus affecting an individual's ability to drive. This is applicable to both general and local anaesthesia. The effects of general anaesthesia will depend on factors such as the duration of anaesthesia, the drugs administered and the surgery performed. The degree of effect of local anaesthesia on driving ability is dependent on dosage and region of administration. Further factors to consider are the effects of analgesics and sedatives.

In cases of post-operative recovery following surgery or procedures under general or local anaesthesia, it is the responsibility of the surgeon and anaesthetist to advise patients not to drive until physical and mental recovery is compatible with safe driving.

Following minor procedures under local anaesthesia without sedation (e.g. Dental block), driving may be acceptable immediately following the procedure. Following brief surgery or procedures with short acting anaesthetic drugs, the patient may be fit to drive after a normal night's sleep. After long surgery or procedures requiring longer lasting anaesthesia, it may not be safe to drive for 24 hours or more.

Quality Assurance

Each Day Surgery unit must have an established system for audit of the outcomes related to anaesthesia care, and include these outcomes in quality assurance and peer review processes

APPENDIX D

GUIDELINES FOR THE ACCREDITATION OF OFFICE-BASED SURGERY FACILITIES

These guidelines have been prepared by the Australian Day Surgery Council to assist accrediting bodies to accredit office-based Day Surgery facilities. The Guidelines are intended as broad principles. Detail may be determined by the accrediting bodies. At some time in the future, health funds or other organisations may contribute to the costs of procedures performed in accredited office-based facilities.

Disclaimer

These guidelines should not be construed as dictating the facilities required to perform safely any diagnostic or surgical procedures. The ultimate judgement of how, where and when a surgical procedure may be best performed must be made by the person who accepts overall responsibility.

CONTENTS

Part 1. Procedures performed under local anaesthesia alone.
Part 2. Procedures performed under local anaesthesia and sedation.

The Australian Day Surgery Council

The Australian Day Surgery Council, formerly the National Day Surgery Committee, was formed by the Australian Association of Surgeons and the Royal Australasian College of Surgeons which then incorporated the Faculty of Anaesthetists (now the Australian and New Zealand College of Anaesthetists) and the Australian Society of Anaesthetists. The Council also includes representatives of hospitals and private health funds. The Australian Day Surgery Council aims to promote Day Surgery of the highest possible standard.

Mr Randall Sach
Chairman, ***Australian Day Surgery Council***

Guidelines prepared by: (and endorsed by ADSC)

Glenda Rudkin:	ANZCA representative Australian Day Surgery Council
Randall Sach:	RACS representative Australian Day Surgery Council

INTRODUCTION

Definition

Office-based surgery is defined as an operation(s) or procedure(s) carried out in a medical practitioner's office or outpatient department, other than as a service normally included in an attendance (consultation). It does not require or involve admission to a Day Surgery/procedure centre or to a hospital as an in-patient.

Although there has been no formal recognition of office-based surgery, a significant group of minor operations/procedures are carried out in practitioner's consulting rooms.

The majority of these operations/procedures are carried out under local anaesthesia or without anaesthesia. However, an increasing number are being carried out under sedation, with or without local anaesthesia.

Australian Practice Standards

The above broad spectrum of minor procedural activity is subject to currently accepted Australian practice standards, including those of infection control and occupational health and safety.

Accreditation of Office-based Surgery Facilities

Accreditation of office-based surgery facilities would best be the responsibility of accrediting organisations. The Australian Day Surgery Council has prepared these Guidelines to assist such organisations in the preparation of specific accreditation criteria.

Accreditation of office-based facilities should not be compulsory. The Guidelines are not intended to apply to simple procedures under local anaesthesia or without anaesthesia such as excision or biopsy of skin lesions, suture of lacerations, removal of sutures and surgical drains, and procedures carried out with topical (surface) anaesthesia, as consulting room services.

It is not envisaged that general anaesthesia will be undertaken as office-based surgery but, if a situation arose whereby general anaesthesia were to be performed in an office-based facility, this would require adherence to standards set by the Australian and New Zealand College of Anaesthetists.

These Guidelines should be interpreted as principles only with detail being the responsibility of the accrediting body.

The following requirements should be met for a facility to be accredited:

PART 1
PROCEDURES PERFORMED UNDER LOCAL ANAESTHESIA ALONE

1. Physical Facilities

1.1 A dedicated procedure room, separate from any consulting room. This room should contain:

- Adequate lighting to allow the procedure to be performed safely
- Non-slip, non-carpeted flooring
- Adequate uncluttered floor space to access and perform resuscitation should this prove necessary.

1.2 A recovery area which is not part of the general waiting room or office.

1.3 Emergency lighting for the procedure room and recovery area.

1.4 Appropriate hand washing facilities for pre-operative hand washing.

1.5 Regular and adequate cleaning.

***2.* Equipment requirements**

2.1 An autoclave or access to sterile instruments from a sterile supply facility.

2.2 For an open procedure, proper provision for haemostasis should be available (e.g. electrosurgical unit).

2.3 Disposable single-use items, including sterile gloves and drapes, ampoules of local anaesthetic, needles, syringes, scalpel blades, and suture material.

2.4 Resuscitation equipment including:

- A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.
- A means of inflating the lungs with oxygen (eg a range of pharyngeal airways and self-inflating bag suitable for artificial ventilation).
- Adequate suction device.

- Appropriate drugs for treating emergencies should include midazolam or diazepam, atropine and adrenaline.

- A range of intravenous equipment.

- Intravenous fluids and infusion sets.

- Intravenous cannulae.

3. Approved Procedures for the Sterilisation of Equipment and the Maintenance of Sterile Operative Fields

3.1 Wherever possible single-use disposable items of equipment should be used, including syringes, needles and ampoules for injection.

Any single-use article or instrument that has penetrated the skin, mucous membrane and/or tissue must be appropriately disposed of immediately after use or at the end of the procedure.

3.2 When re-useable items of equipment are used provision must be made for:

- **Physical Cleaning**
  This is a process for the removal of micro-organisms and biohazardous materials from the surface of an object. Thorough physical cleaning of instruments to remove blood and other debris must always be performed prior to disinfection/sterilisation.

- **Disinfection**
  This is a process for eliminating all micro-organisms other than bacterial spores.

- **Sterilisation**
  This is a process for destroying all forms of microbial life, including bacterial spores. The most effective and reliable form of sterilisation is by steam under increased pressure (autoclaving). Australian Sterilizing standards AS 4187 and Standards for Endoscopic facilities and Services apply.

  All instruments, materials and medications introduced into the body tissues must be sterile. Such instruments may be pre-sterilised single-use items, or re-useable items which have been sterilised before use.

  Instruments used for internal examinations of mucous membranes (eg vaginal speculum, rigid sigmoidoscopes and flexible endoscopes) must not

have the capacity to transfer harmful micro-organisms between patients. They must be sterilised or disinfected.

3.3 All biomedical equipment must comply with Australian Standards AS-3551.

3.3.1 Sterile drapes where necessary.

4. Staff

4.1 Clinical support and responsibilities for equipment with the facility should be provided by appropriately trained personnel. Office staff should not be seconded for this purpose.

4.2 All staff involved in the performance of procedures should have their blood borne virus status assessed and maintain appropriate immunisation against Hepatitis B.

4.3 All staff should be familiar with procedures to be followed in the event of a needle stick injury, which should be fully documented.

4.4 All staff should be trained in basic cardiopulmonary resuscitation procedures and in the checking of equipment and emergency drugs used for resuscitation purposes.

4.5 All staff must be conversant with a protocol for the management of a patient who has collapsed.

5. Patient Transfer

An arrangement should exist with a nearby accredited hospital for the transfer of patients in the event of unexpected serious or potentially serious developments.

6. Medical Records

6.1 An adequate anaesthetic and surgical record must be maintained. Separate documentation of each procedure should be kept in a log book, including date, time, duration, personnel involved in the procedure, and any associated problems or complications.

6.2 Follow up arrangements and post-operative wound care must be clearly outlined to the patient, with written instructions when appropriate.

7. **Waste Disposal**

   Disposal of contaminated waste, including sharps, should be properly managed via an arrangement with a licensed contractor.

8. **General**

   8.1 An appropriate management structure which has the ability to address continuous quality improvement (CQI) issues.

   8.2 Occupational health and safety guidelines for an operating theatre should be readily available and should be followed. This should include fire safety and evacuation procedures.

   8.3 Documentation of regular staff training in cardio-pulmonary resuscitation, the use of emergency drugs and the care and maintenance of equipment.

PART 2

PROCEDURES PERFORMED UNDER LOCAL ANAESTHESIA AND SEDATION

Definition:
Sedation for diagnostic and surgical procedures (with or without local anaesthesia) includes the administration by any route or technique of any drug which results in depression of the central nervous system.

All guidelines for procedures performed under local anaesthesia alone apply. (See Part 1). In addition the following:

1. Physical Facilities

1.1 The plan should allow for:

- an admission and reception area
- pre and post-operative patient holding areas
- appropriate utility room
- toilets suitable for disabled persons
- refreshment facilities
- vehicle access area

1.2 Procedure room

- adequate size for the procedures undertaken including adequate uncluttered floor space to perform resuscitation should this prove necessary.
- appropriate lighting, ventilation and suction
- appropriate equipment for the procedures undertaken
- an operating table or trolley which can be readily tilted
- quality of staff appropriate to the procedures undertaken.

1.3 Recovery room

- close to the procedure room with adequate lighting and adequate uncluttered floor space to perform resuscitation should this prove necessary.
- comfortable reclining seating for patients to complete recovery prior to discharge
- patients should be supervised by appropriately trained nursing staff
- ready access to resuscitation equipment, including oxygen and suction.
- patients should not leave the recovery room unaccompanied.

1.4 Discharge area should include:
- wheel chair access
- vehicle access area
- ambulance access

2. Drugs and Equipment

2.1 A supply of oxygen and suitable devices for the administration of oxygen to a spontaneously breathing patient.

2.2 A means of inflating the lungs with oxygen (eg a range of pharyngeal airways and self-inflating bag suitable for artificial ventilation)

2.3 Appropriate drugs for cardiopulmonary resuscitation and a range of intravenous equipment. Emergency drugs should include the following:

- Adrenaline
- Atropine
- Dextrose 50%
- Lignocaine
- Naloxone
- Flumazenil

2.4 A pulse oximeter. Continuous patient monitoring by pulse oximetry is required when intravenous sedation is used. Equipment must alarm when set limits are exceeded.

2.5 Ready access to a defibrillator

2.6 An adequate suction device

3. Staff

- An appropriately trained registered nurse or health professional should be present for theatre and/or recovery.
- An appropriately trained assistant must be present during the procedure to monitor the level of consciousness and cardio-respiratory function of the patient. The assistant must be competent in cardiopulmonary resuscitation.
- The operator may provide non-intravenous sedation and be responsible for care of the patient, on the condition that rational communication to and from the patient is continuously possible during the procedure.
- If at any time rational communication is lost, the operator must cease the procedure and devote his/her entire attention to monitoring and treating the

patient until such time as another practitioner becomes available to monitor the patient and to take responsibility for any further sedation, analgesia or resuscitation.

- An anaesthetist should be present if intravenous sedative drugs are being administered .
- If loss of consciousness or loss of rational communication is sought as part of the technique, an appropriately trained anaesthetist must be present to care exclusively for the patient.
- Techniques, which compensate for anxiety or pain by means of heavy sedation, must not be used unless an anaesthetist is present.

- **The practitioner administering the sedative drugs must have sufficient basic knowledge to be able to:**

  - Understand the actions of the drug or drugs being administered
  - Detect and manage appropriately any complications arising from these actions. In particular doctors administering sedation must be skilled in airway management and cardiovascular resuscitation.
  - Anticipate and manage appropriately the modification of these actions by any concurrent therapeutic regimen or disease process.

- A written record of the dosages of drugs and the timing of their administration must be kept in the patient's records. Such entries should be made as near to the time of administration of the drugs as is possible.

- A policy and procedure manual should be available to all staff.

4. Patient Assessment

4.1 The patient should be assessed before the procedure.

Documentation should include:

- A concise medical history and examination (including blood pressure measurement)
- Informed consent
- Any instructions for preparation and discharge procedure

4.2 If the patient has any serious medical condition or danger of airway compromise, or is a young child or is elderly, an anaesthetist should be present to monitor the patient during the procedure.

4.3 Patient assessment can be assisted by:

A standardised anaesthetic questionnaire
Preliminary nurse assessment
Prior anaesthetic referral in cases of doubt as to suitability for office based surgery.

4.4 Patient information in an understandable written format must include:

- General information about the procedures followed in the office based facility.
- Limited solid food may be taken up to six hours prior to operation.
- Unsweetened clear fluids totalling not more than 200 ml per hour may be taken up to three hours prior to operation.
- Only medications or water ordered by the anaesthetist should be taken less than three hours prior to operation.
- An H_2-receptor antagonist should be considered for patients with an increased risk of gastric regurgitation.
- These guidelines may be modified for some patients, particularly infants and small children, on advice from the anaesthetist.

5. Selection Guidelines

5.1 Procedures suitable for office-based surgery include those with:

- A minimal risk of peri-operative haemorrhage.
- A minimal risk of post-operative airway compromise.
- Post operative pain controllable by outpatient techniques.
- A rapid return to normal fluid and food intake.

5.2 Patient requirements for office-based surgery include:

- A willingness to have the procedure performed together with an understanding of the process and ability to follow discharge instructions.
- Physical status of ASA 1 or 11. Medically stable ASA 111 or 1V patients may be accepted for office based surgery following consultation with the anaesthetist concerned.
- In all cases, the ultimate decision as to the suitability of a patient for office based surgery is that of the surgeon and/or anaesthetist. The decision as to the type of anaesthesia must remain in the province of the anaesthetist and will be based on surgical requirements, patient considerations, the experience of the anaesthetist and the facilities available.

5.3 Social requirements for office-based surgery include:

- A responsible person able to transport the patient home in a suitable vehicle.
- A responsible person at home for at least the first night after discharge from the facility.

Note:

- A responsible person is an adult who understands the instructions given and is physically and mentally able to make decisions for the patient when appropriate.

6. Discharge

- The patient should be discharged only after an appropriate period of recovery and observation in the procedure room or in an adjacent area that is adequately equipped and staffed.
- The patient's discharge should be authorised by the practitioner who administered the drugs, or another suitably qualified practitioner. The patient should be discharged to the care of a responsible adult to whom written instructions are given. These should include emergency phone numbers.
- Should the need arise the patient must be transferred for appropriate medical care.

References:

- Australian and New Zealand College of Anaesthetists Policy Documents: TE9,T1,T3,T4,T5,T6,P4,P6,PS7,P9,P15,P18,P19,P20,P21,P24,PS36.

- Infection Control in Surgery. Policy Document, Royal Australasian College of Surgeons, July 1998.

- Day Surgery. Report and recommendations of the Australian Day Surgery Council, Royal Australasian College of Surgeons, 1997.

- Standards for Endoscopic Facilities and Services. February 1998 Gastroenterological Society of Australia and Gastroenterological Nurses Society of Australia.

- Reuse of Single-Use Medical Devices: Making Informed Decisions. ISBN 0-941417-52-2:ECRI 1996

- National Occupational Health and Safety Commission. *Control of workplace hazardous substances: National code of practice for the control of workplace hazardous substances [NOHSC:0003(1993)] and National model regulations for the control of workplace hazardous substances [NOHSC:0002(1993)], Australian Government Publishing Services, Canberra.*

- Draft Crises Management Manual. Cover ABCD. A Swift check. Australian Patient Safety Foundation. GPO Box 400 Adelaide SA 5001. 1996.

- Australian Council on Health Care Standards. (1990), Accreditation Guide-Day Procedure.

- Australian Standard. Code of practice for cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities. AS 4187 –1994.

- Australian Standard for Biomed AS3551.

- ACORN Operating Room Nurses 1999.

- Occupational Health, Safety & Welfare Regulations, 1995. Fire and Evacuation.

- Guidelines on Conscious Sedation for Diagnostic, Interventional, Medical and Surgical procedures, 2nd June 2001. PS9 (being an amalgamation of documents P9, P19, P21 P24, in references, & P36)

- Reference. Anesthesiology Volume 24, pl l l, 1963

- Lichtor J, Alessia R, Lane B, "Sleep tendency as a measure of recovery after drugs used for ambulatory surgery". Anesthesiol. 2002; 96: 878-883.

- Refer ANZCA College Bulletin Vol. 11, No. 4, November 2002.

APPENDIX E

REGISTRATION, ACCREDITATION AND CONTROL OF DAY SURGERY FACILITIES

1. In order to ensure that the standards of care are maintained, the Council recommends that Day Surgery facilities be registered with the State Health authorities and that registration be on the basis of accreditation on an agreed set of standards.

2. To administer the facilities and afford proper mechanisms for accreditation and control, a three-tiered structure of committees is proposed:

2.1 An Australian Day Surgery Council Coordinating Committee

The functions of this Committee will be:

2.1.1 to establish national standards of patient care in, and advise on accreditation of, Day Surgery facilities and office based surgery facilities;

2.1.2 to communicate policy to State and Commonwealth authorities;

2.1.3 to liaise with other bodies in the medical, para-medical, nursing, administrative, governmental and insurance fields;

2.1.4 to advise on any other matters relating to the overall conduct of Day Surgery facilities.

It is recommended that the current Council (i.e. representatives of the Royal Australasian College of Surgeons, Australian and New Zealand College of Anaesthetists and the Australian Society of Anaesthetists with power to co-opt additional representatives as required), be the Australian Day Surgery Council Coordinating Committee.

2.2 A Medical Executive Committee in each Day Surgery facility.

The functions of this Committee are:

2.2.1 to advise and assist the governing body of each Day Surgery facility in the maintenance of standards of patient care and facility services;

2.2.2 to be responsible for, and advise the governing body on, delineation of privileges of the medical staff;

2.2.3 to monitor the performances of each Day Surgery facility.

The composition of these Committees is a matter for the particular institution controlling the Day Surgery facility to determine.

2.3 Accreditation Body

The ADSC supports an accreditation process of all Day Surgery facilities. This process should be carried out by bodies established for that purpose. These currently include, Australian Council of Health Care Standards and ISO 9000.

Contact details:
Australian Council of Health Care Standards
Macarthur Street, Ultimo, NSW 2007
Tel: 02 9281 9955
Fax: 02 9211 9633
Email: achs@achs.org.au
Web: www.achs.org.au

International Organisation for Standardisation (ISO 9000)
GPO Box 5420
Sydney, NSW 2001
Tel: 61 2 82 06 60 00
Fax: 61 2 82 06 60 01
Email: intsect@standards.com.au
Web: www.standards.com.au

APPENDIX F

COMMONWEALTH LEGISLATIVE REQUIREMENTS

Private Hospitals and Day Procedure Centres (DPCs) are both governed by the National Health Act 1953. National requirements for general and professional standards of management, quality, accreditation, and professional credentialing, medication safety, clinical and performance indicators, patient care processes and inclusion of the consumers are the same for all, public and private hospitals and Day Hospitals.

The Second Tier requirements, as set by the Commonwealth and introduced in September 2001 state the minimum requirements as set out by the Commonwealth Department of Health and Aged Care's 2nd tier default benefit determination (HBF 721/PH 455) circular. These requirements are applied to private hospitals and Day Surgery units.

For Quality and Safety

The National requirements for general and professional standards of: -

- State licensing
- Management,
- Quality assurance and accreditation
- Medication safety,
- Informed financial and clinical consent
- Professional credentialing,
- Patient care processes for preadmission, admission and discharge policies and
- The inclusion of the consumers in the decision process is the same for all hospitals and Day Hospitals.

2nd Tier compliance
The Second Tier requirements as set by the Commonwealth and introduced in September 2001 state the minimum requirements.

Explanation: The Department of Health and Ageing has released Circular HBF 792/PH 521, dealing with the arrangements for Second Tier benefits. The Circular reminds private hospitals and day hospital facilities that from 1 September 2002, facilities seeking to become (or remain) eligible to receive Second Tier default benefits will need to comply fully with all Second Tier accreditation criteria (i.e. including clause 3).

Each State also has regulations relevant to the licensing requirements of facilities and these regulations must be applied as a minimum level of standard or compliance.

State Law
State Law Compliance relates to Licensing of the facility in order to qualify for a Commonwealth Provider number. Each state has varying requirements.

Refer to PHIAC (Private Health Industry Quality and Safety Committee) licensing sub group.

Information paper "State and Territory Licensing Arrangements for Private Facilities', August 2003.

APPENDIX G

ACCREDITATION, SAFETY & QUALITY:

Agency for Healthcare Research & Quality www.ahcpr.gov

Ambulance Services:

- VICTORIA
    - www.ambulance.vic.gov.au
- NEW SOUTH WALES
    - www.asnsw.health.nsw.gov.au
- SOUTH AUSTRALIA
    - www.saambulance.com.au
- QUEENSLAND
    - www.ambulance.qld.gov.au
- WESTERN AUSTRALIA
    - www.ambulance.net.au
- TASMANIA
    - www.dhhs.tas.gov.au/ambulance
- NORTHERN TERRITORY
    - www.nt.gov.au/pfes
- AUSTRALIAN CAPITAL TERRITORY
    - www.esb.act.gov.au/as/as.htm

Australian Emergency Services Information
www.australiatravelsearch.com.au/trc/emergency.html

Austroads	www.austroads.com.au
Australian Council on Health Care Standards	www.achs.org.au
Benchmark- Independent Certification Services	www.benchmark.com.au
Food Handling	www.foodstandards.gov.au Check your state health department and local council regulations to ensure you comply.
Joint Accreditation Systems of Australia and New Zealand	www.jas-anz.com.au
International Organization for Standardization	www.iso.com
Occupational Health & Safety	www.nohsc.gov.au
Safety And Quality Council	www.safetyandquality.org
Sentinel Event Reporting	www.health.vic.gov.au/clinrisk/sentin

Standards Australia		www.standards.com.au/catalogue/script/search.asp
Workcover:	Victoria:	www.workcover.vic.gov.au
	NSW	www.workcover.nsw.gov.au
	Western Australia	www.workcover.wa.gov.au
	Queensland	www.qld.gov.au
	South Australia	www.workcover.com
	Tasmania	www.wsa.tas.gov.au
	Northern Territory	www.worksafe.nt.gov.au
Workplace OH&S		www.workplaceohs.com.au

BIBLIOGRAPHY/RESOURCE/REFERENCE LIST:

ADSNA Guidelines	www.adsna.info
ACORN Standards	www.acorn.org.au
American Society of Anaesthesiologists	www.asahq.org
AS-4187	www.standards.com.au
Australian Academy of Medicine and Surgery	www.aams.org.au
Australian Adverse Drug Reactions Bulletin	www.tga.gov.au/adr/aadrb/htm
Australian Standards	www.standards.com.au
Australian Nursing Federation (ANF	www.anf.org.au
British Association of Day Surgery	www.bads.co.uk
Centre for Disease Control – America	www.cdc.gov
GENCA Guidelines	www.genca.org
Hospital Casemix Protocol Data Collection	www.health.gov.au/casemix/hcp/hcpmain1.htm
National Health & Medical Research Council–InfectionControlGuidelines	www.nhmrc.gov.au/publications/synopses/ic6syn.htm
Victorian Drug Usage Advisory Committee	www.vduac.org.au

JOURNALS:

Ambulatory Surgery Journal	intl.elsevierhealth.com/journals/amsu/
Day Surgery Australia	www.adsna.info

AUSTRALIAN DAY SURGERY COUNCIL:: www.surgeons.org/wedo

INTERNATIONAL ASSOCIATION FOR AMBULATORY SURGERY:

International Association for Ambulatory Surgery Standards:

- Ambulatory Surgery – Patient Selection Criteria:
- Clinical Indicators for Ambulatory Surgery
- Day Surgery with Extended Recovery
- Discharge Criteria Following Day Surgery
- Patient Satisfaction

Reference:	International Association For Ambulatory Surgery
Website:	http://www.iaas-med.org/
Email:	d.dejong@vumc.nl

- Day Surgery Categorisation
- Performance indicators
- ACHS documentation

RELATED PROFESSIONAL BODIES:

Australian and New Zealand College of Anaesthetists	www.anzca.edu.au
Australian College of Operating Room Nurses	www.acorn.org.au
Australasian Day Surgery Association	www.adsa.asn.au
Australian Day Surgery Council	http://www.surgeons.org/wedo
Australian Day Surgery Nurses Association	www.adsna.info
Australian Medical Association	www.ama.com.au
Australian Nursing Council	www.anci.org.au
Australian Nurses Federation	www.anf.org.au
American Society of Anaesthetists	www.asahq.org
Australian Society of Anaesthetists	www.asa.org.au
British Association of Day Surgery	www.bads.co.uk
Federated Ambulatory Surgeons Association	www.fasa.org
Gastroenterological Nurses College of Australia	www.genca.org
Joanna Briggs Institute	www.joannabriggs.edu.au
National Health & Medical Research Council	www.health.gov.au/nhmrc
Private Health Insurance Administration Council	www.phiac.gov.au
Royal Australian & New Zealand College Of Ophthalmologists	www.ranzco.edu
Royal Australasian College of Surgeons	http://www.surgeons.org
Society for Ambulatory Anesthesia (Samba)	www.sambahq.org
The Cochrane Collaboration	www.cochrane.org

STATE HEALTH DEPARTMENTS:

Australian Capital Territory	http://www.health.act.gov.au/c/health
Victorian Department of Human Services,	http://www.dhs.vic.gov.au
New South Wales Health	http://www.health.nsw.gov.au/
Northern Territory Government	http://www.health.nt.gov.au/
Queensland Health	http://www.health.qld.gov.au/
South Australian Dept. of Human Services	http://www.dhs.sa.gov.au/
Tasmanian Dept. of Health & Human Services	http://www.dhhs.tas.gov.au/
Victorian Government Health Information	http://www.health.vic.gov.au/
Western Australian Government	http://www.health.wa.gov.au/

COMMONWEALTH HEALTH DEPARTMENT:

Commonwealth Health Department**:**	http://www.health.gov.au/
Commonwealth Circulars	http://www.health.gov.au/privatehealth/providers/circulars.htm