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NURSING AND UNIT ORGANISATION-NEW CHALLENGES

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Cir. May. Amb. 2005, Vol. 10 (Suplemento 1): 32-33.

BACKGROUND

Although the further development of nursing roles plays a major part in the redesign of elective surgery, progressive and successful day surgery is based on teamwork which requires concerted effort and energy from all parties.

In the UK, the NHS has a culture of continual change which presents many challenges. By exploring these challenges, potential barriers and opportunities, it enables the multi-professional team to find new ways of working to further develop the surgical services. In the UK, due to devolved parliament, ministering of health varies in Scotland, England, Wales and Northern Ireland. For example, with specific reference to day surgery, there are variations in the targets set for the same procedures in Scotland and England and also variation in the type of procedures within the "baskets". Regardless of these facts, from the results of the Audit Commission report 2005 and Audit Scotland report 2004, it is clear that there is further scope to increase day surgery. There is commonality regarding the **barriers** and ways to overcome these challenges. Some of the barriers cited are clinicians preference for inpatient surgery, poor management and organisation and inappropriate and inadequate use of facilities.

POLITICAL DRIVERS

Following a recent review of all services within the NHS, the DH identified 10 key High Impact Changes of which day surgery is No.1. Day Surgery should be the default of all elective surgery with the aim to undertake 71.9% on a day case basis. This **pressure to deliver** is a result of The NHS Plan and the 2002 Planning and Priorities Framework (PPF) that set waiting times targets for 2005 including:

1. six months maximum wait for inpatient treatment
2. three months maximum wait for outpatient treatment
3. twenty-four hours maximum wait for a primary care professional and 48 hours maximum wait for access to a General Practitioner. In addition, the NHS Plan and the PPF set a further target of:

4. three months maximum wait for inpatient treatment by 2008.

These political drivers to increase efficiency and effectiveness include the **empowerment of patients** who, at initial consultation, can choose one of 4 or 5 hospitals based on the best waiting times and quality of care, Choose and Book Scheme. Therefore the impact of market forces pressurises the team to redesign the services in terms of capacity planning and quality improvement from referral to post-discharge support. Due to constant changes and progress, the design, **organisation and management** should reflect the ever changing needs and requirements of patients, staff and the service.

Technological advances such as increase in minimal access surgery, laser procedures, anaesthetic techniques and medications continue to revolutionise elective surgery, increasing the transfer of inpatients to day surgery, from day surgery to outpatients and Primary Care. By pushing the boundaries regarding type of procedure and complexity of patient, the multidisciplinary team requires not only the appropriate skills and expertise, but the appropriate systems to manage risk and stream line the service from referral to post-discharge follow-up. Training and education is essential and embedding evidence-based and best practice into the care pathways aims to improve patient outcome and standardise care.

DEVELOPING ROLES

More challenges are presented from the impact and implications of the European Working Time Directive(EWTD) which further diminishes the demarcation lines between doctors and nurses. Therefore there are more opportunities for the development of **new roles for nurses** and theatre practitioners. Nurse-led services, such as, pre-operative assessment and discharge already established in many units in the UK, may need to take it one step further. For example, more nurses will be trained to undertake physical examinations and provide post-operative follow-up clinics.

Nurses are already advancing practice as endoscopists, cystoscopists and minor operation nurse practitioners. There are now pilot sites in the UK where advanced scrub practitioners undertake varicose vein surgery and inguinal hernia repair. Over the past year, the Royal College of Anaesthetists(RCA) is piloting a training programme for nurse anaesthetists across certain sites in the UK. The impact of these developments has a twin edged sword. Positive impact provides nurses with the choice of a clinical career pathway rather than solely managerial. Negative impact is the slow draining of the nursing service as these practitioners take on the roles of the junior doctors. Therefore adding to the global problem of poor nurse recruitment and retention. But is this new? Over many decades, nurses have progressed the services and taken on roles previously under

the doctors' remit. Therefore further challenges lie in the **multi-skilling** of staff and the further development of **Health Care Assistants (HCA)** / Clinical Support Workers. Some hospitals are proactively developing these HCAs, for example, scrub assistants. We need to ensure that the Agenda for Change, new terms and conditions for healthcare workers, provides the right framework to support the **generalists and specialists** in terms of education, career structure, evaluation, regulation and resources.

When faced with new challenges, reviewing our strategy, structure, systems, staffing and skills provides the first step in finding ways to improve the service. Nurses are no longer perceived as just another resource, but as a dynamic influence and force in the further development and progress of elective surgery.

- Day Surgery- A Good Practice Guide 2004
www.modern.nhs.uk/day
- Royal College of Anaesthetists
www.rcoa.ac.uk
- Day Surgery in Scotland-reviewing progress
April 2004: www.audit-scotland.gov.uk
- Audit Commission 2005
www.audit-commission.gov.uk

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THE EDUCATIONAL ROLE OF NURSING: PREADMISSION CLINICS, SELF-CARE AFTER AMBULATORY SURGERY

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Cir. May. Amb. 2005, Vol. 10 (Suplemento 1): 33-33.

BACKGROUND

There is an increasing trend around the world with the number of patients undergoing surgical and diagnostic procedures within the ambulatory surgery setting. There is also an increase in the variety of procedures being performed. Australia is no exception. Therefore, it is vital that the patient is appropriately selected and carefully prepared for their self care upon discharge.

The nurse has a key role in this process.

During this session, I will present the following:

- The types of preadmission assessment practiced in Australia.
- The role of the nurse in preadmission assessment.

- How we aim to ensure self care after ambulatory surgery.

Preadmission assessments can take many forms in Australia. They may be any of the following:

- A questionnaire (which collects information about both past and present medical history and social circumstances) returned to the facility prior to admission.
- A phone call by a registered nurse to obtain information otherwise collected by the questionnaire.
- A phone call as a result of the information obtained by the questionnaire.
- A face to face assessment by a nurse with or without the questionnaire.
- A face to face assessment at a preadmission clinic with a nurse as per the policy of the facility.
- A face to face assessment by a medical officer as a result of the nurse's assessment and/or questionnaire.

Self care after ambulatory surgery can take many forms in Australia. Best practice would advise that education regarding self care should commence at the time of consultation with the surgeon at the time of booking and confirming the procedure.

The nurses' role can commence at the time of booking to commence the important education required for successful self care post discharge. Many facilities will contact the patient prior to admission with one or more of the following:

- Written information.
 - Telephone.
 - Preadmission clinic .
- Information would include:
- Pain / Nausea management.
 - Dressings or wound care.
 - Fluids and diet.
 - Support required by family.
 - Level of activity permissible.
 - Emergency Contacts and planned medical review appointment.

Finally, how can we be sure our patients are successful with their self care at home following discharge? Many facilities undertake post discharge follow-up by phone or consultation where they can reinforce further education and/or reassure patients and their families that everything is as planned.

Finally, my presentation will reflect not only the practice in my facility which specializes in Ambulatory Surgery, but data and anecdotes from stand alone as well as integrated centres in a number of facilities within both the Private and Public sector.

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ENDOSCOPY PERFORMED BY SPECIAL TRAINED NURSES

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Cir. May. Amb. 2005, Vol. 10 (Suplemento 1): 34-34.

INTRODUCTION

In need of more Endoscopists to diagnose Colorectal Tumours, as recommended by the Danish Institute for Health, our department has trained two Nurses to perform flexible sigmoideoscopy.

This is a method to take advantage of the experienced Nurses already available in the department, and a good prospect of increasing qualifications as a Nurse.

METHOD

To educate qualified Nurses, a training programme was made containing a theoretical and a practical part.

The sigmoideoscopies, performed by the Nurses, are recorded on a CD-rom.

The Endoscopistnurse and an Assistant Nurse work together in the Operating Theatre.

A Nurse in the Recovery Room welcomes and prepares the patient to the examination, and finally she discharges the patient immediately after the examination.

If the patient has been sedated, a short rest in the Recovery Room is usually required.

The Endoscopistnurse makes a case sheet and the patient is informed about the procedure. After the examination the patient is informed about the result of the examination, and at the end of the day final treatment plans are made conferring a Consultant.

The Assistant Nurse in the Operating Theatre cares for the patient during the examination, and she assists if biopsies are taken. Furthermore, it is her responsibility to clean and prepare the endoscopes during the day.

If needed during the examination the nurse can call a Consultant for assistance. This is essential when discovering malignant tumours or inflammatory bowel diseases in order to start treatment immediately.

RESULTS

I have independently performed sigmoideoscopy for 2 years. During this period I have examined approximately 400 patients. An average of 9-10 patients is examined during a days work. Most of the patients suffer from Irritable Bowel Syndrome, Inflammatory Bowel Diseases and Haemorrhoids, but frequently I discover Colorectal Tumours. There have been no perforations or other major complications to the procedures.

CONCLUSION

The period from referral to examination is reduced significant by allowing the Special Trained Nurses to perform the endoscopies.

We experience that the patients are satisfied to be examined by Nurses.

Judged by the Supervising Surgeon, the quality of the examinations is at least as good as examinations performed by the Gastroenterology Surgeons at the Hospital, who by the way are pleased with this arrangement. It leaves them available for other tasks during the day.



PARALLEL SESSION 4
FAST-TRACK SURGERY
Chairmen: Pelissier E, (France).
Gupta A, (Sweden).

HOW THE SURGEON CAN CONTRIBUTE TO REDUCE POSTOPERATIVE PAIN AFTER ABDOMINAL SURGERY?

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Cir. May. Amb. 2005, Vol. 10 (Suplemento 1): 34-35.

Postoperative pain is due to the direct stimulus of nervous endings by the surgical trauma and to the production of algogenic substances by the injured tissues, which in turn keep up irritation of nociceptive receptors. After abdominal surgery the main cause of pain is the incisional wound, but proper to abdominal surgery, the intestinal ileus is another cause of pain and discomfort. And finally many other factors linked to surgery, which we name "environmental factors", like drains and all sorts of tubes and catheters, contribute to pain and discomfort.

Effective control of pain is a very important contribution to postoperative rehabilitation, by reducing the surgical stress and facilitating early active mobilization.

The surgeon can effectively contribute to reduce the pain originating from the surgical access. Laparoscopic surgery is the most effective mean to reduce the wound injury and consequent pain. But for some procedures, like hernia for example, the benefit of laparoscopy is limited compared to the possible occurrence of rare but severe complications. Moreover many major surgical procedures are still performed by laparotomy.