PLENARY SESSION 1

UPDATE ON INTERNATIONAL DEVELOPMENTS AND BARRIERS: PART 1

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REVIEW OF NATIONAL REPORTS/ IAAS BASKET UPDATED. ACTIVITY FOR 20 COMMON PROCEDURES

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An International Survey has been perfomed with the goal to achieve data of the day surgery activity in 30 procedures that typically may be done in a day surgery setting or are at the cutting edge in day surgery.

The procedures are: Cataract, Squint, Myringotomy with tube insertion, Tonsillectomy, Rhinoplasty, Broncho-Mediastinoscopy, Surgical removal of tooth, Endoscopic female sterilisation, Legal abortion, Dilatation and curettage of uterus, Hysterectomy (LAVH), Repair of cysto- and recto-cele, Knee arthroscopy, Arthroscopic meniscus, Removal of bone implants, Repair of deform. on foot, Carpal tunnel release, Baker cyst, Dupuytrens contractur, Crusiate ligament repair, Disc operations, Local excision of breast, Mastectomy, Laparoscopic cholecystectomy, Laparoscopic antireflux, Haemorrhoidectomy, Inguinal hernia, Circumcision, Orchidectomy + -pexi, Male sterilisation, TURP, Colonoscopy w/wo biopsy, Removal of colon polyps, Varicose veins, Bilat: breast reduction, Abdominoplasty, Pilonoidal cyst.

A survey has been undertaken in the member countries and other interested contries or regions. Data concerning organisation and reimbursement for day surgery are asked for as well.

Data comparing the countries and regions are presented. Data completeness varies between countries.

It is concluded that it is an important issue for the IAAS to conduct benchmark surveys in order to keep the governments focus on the Day Surgery development and the incitements for the increase in day surgery activity.

QUALITY MANAGEMENT: THE CHALLENGE OF MAJOR AMBULATORY SURGERY FOR THE FIRST DECADE OF 20TH CENTURY IN SPAIN

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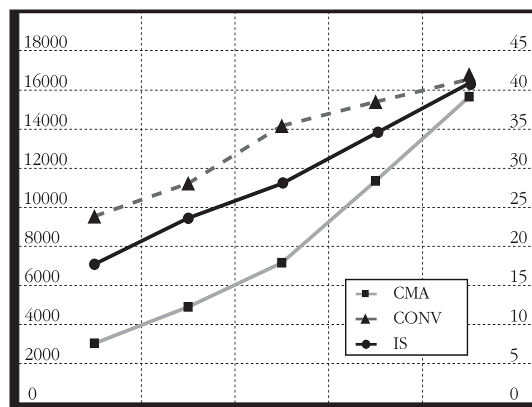
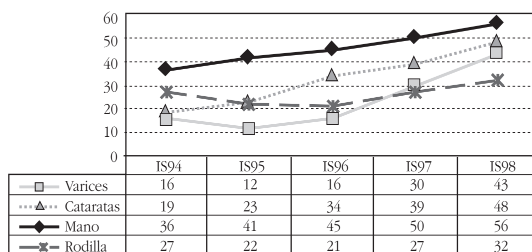
Major Ambulatory Surgery in Spain has got a spectacular development since its beginning in the first nineties of the past century, following the trail of pioneer units as those from Hospital of Viladecans in Catalonia or El Tomillar in Andalucia are. The leadership of people like Dr. Colomer or Dr. Marín with others has achieved a consolidated and prestigious pattern of organization for Major Ambulatory Surgery for Spain.

The aim of this conference is not to analyse in detail the activity carried on in our country, but in figures 1 and 2 substitution index for standardized





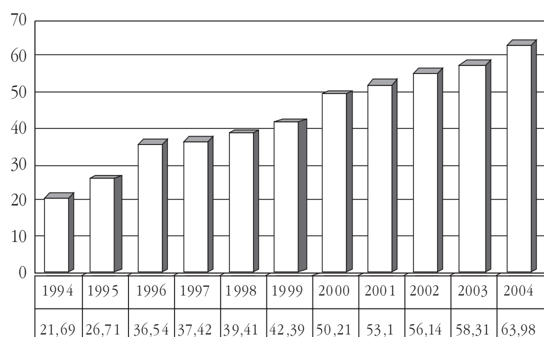
	IS94	IS95	IS96	IS97	IS98
Varices	16	12	16	30	43
Cataratas	19	23	34	39	48
Mano	36	41	45	50	56
Rodilla	27	22	21	27	32

procedures in a multicentric study made in Catalonia (21 hospitals, 1998-2000) are shown. The tendency initiated in early 90's has been progressively increasing, the hospitals have created Major Ambulatory Surgery Units and complexity of procedures is each time bigger. In our own Hospital, the overall substitution index is 63.9% for programmed surgery in 2004 (figure 3).

Once the model is consolidated, and a wide implantation reached, the challenge for Major Ambulatory Surgery in Spain is quality management.

Major Ambulatory Surgery Units has tried to offer maximal safety and comfort for both the patient (external client) and health professionals (internal client).

INDICE DE SUSTITUCIÓN. HOSP. MATARO



The use of monitoring of quality indicators and satisfaction questionnaires are ordinary in the larger part of Units. The above mentioned multicentric study had a prospective phase in which 2038 inquiries by phone were made to patients operated in the Major Ambulatory Surgery Units; 8 cancellations, 21 early admissions, 1 late admission, 4 reoperations and 9% of phone calls were registered. The satisfaction level of the patients was 77 (range 40-100), the best indicator was surgeon and nurse management and the worse the waiting time.

The challenge for that decade is to reach a quality management model that allows us to get the excellence through a continuous quality improvement process.

The first step is to achieve a consensus about which quality indicators have to be monitored, the second one the definition and calculation, and the last the application to both the overall activity of the units and to the specific standard surgical procedures.

In the larger part of Spain EFQM model is the reference for quality aspects in health services. The model ISO 9001 is more restrictive and is orientated to the patient, its requisites and wishes.

Major Ambulatory Surgery Units are suitable to be managed by ISO 9001/2000 norm because their specificity and to be transversal organizations in which several departments of the hospital are engaged.

Advantages:

- The management by process.
- Oriented to results. Quality indicators used.
- Oriented to the client. Satisfaction levels.
- It induces to the protocols in clinical practice.
- Preventive actions.
- Corrective actions.
- Internal control.
- Manager review.

This method of management binds to adequate all the actions to a continuous improvement of services.

The major Ambulatory Surgery unit of the Hospital of Mataró achieved in April 2004 the ISO 9001/2000 Certificate (figure 6).

The process of evaluation was divided in five:

- Selection of the patients, that includes the selection of the surgeon, selection of the anesthesiologist and surgical daily program. Indicators considered were: patients rejected by the anesthesiologist (0.79%), changes in the surgical program and delay of operation after surgical indication by the surgeon.
- In patient process: cancellations (1.41%), time for the patients waiting for surgery over 60 min. (7.9%) and events in the in patient process.
- Operative process: Recovery stay under 90 minutes (3.6%).
- Discharge process: postoperative mean stay

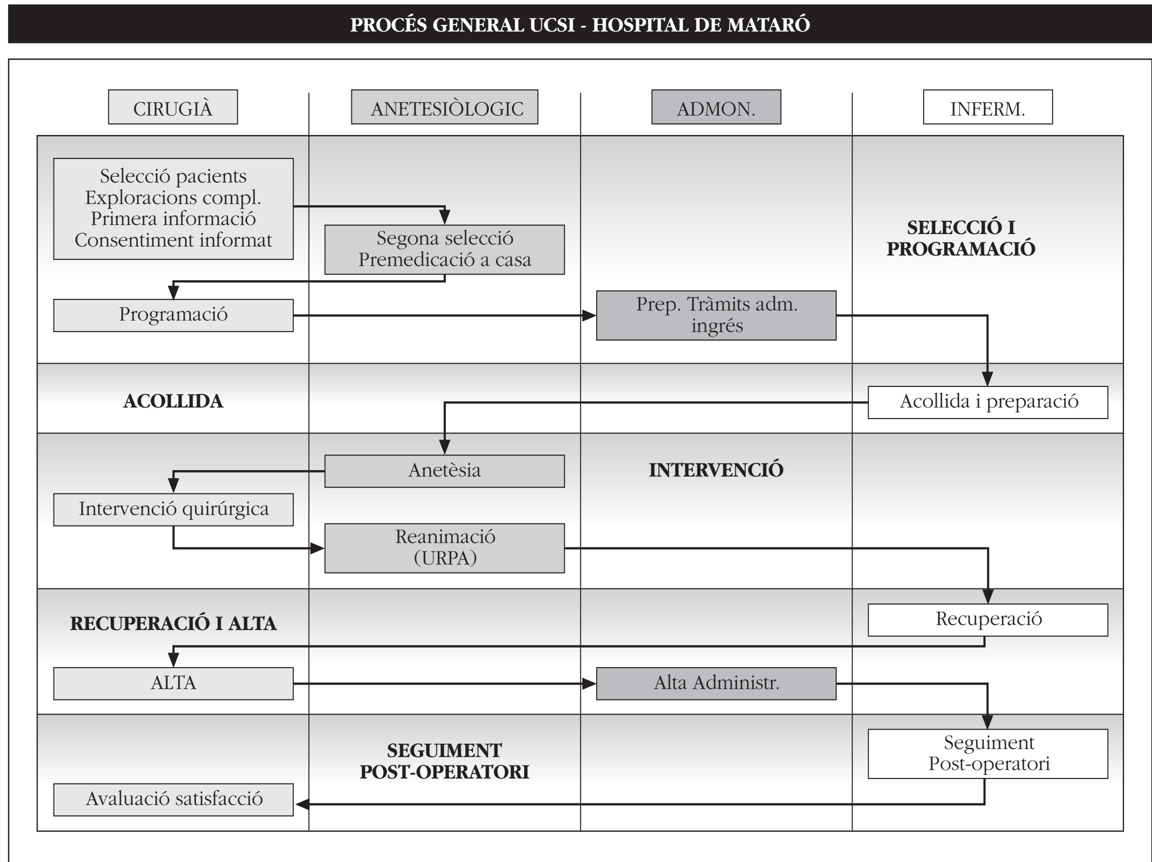
ACTIVIDAD 1994-2004

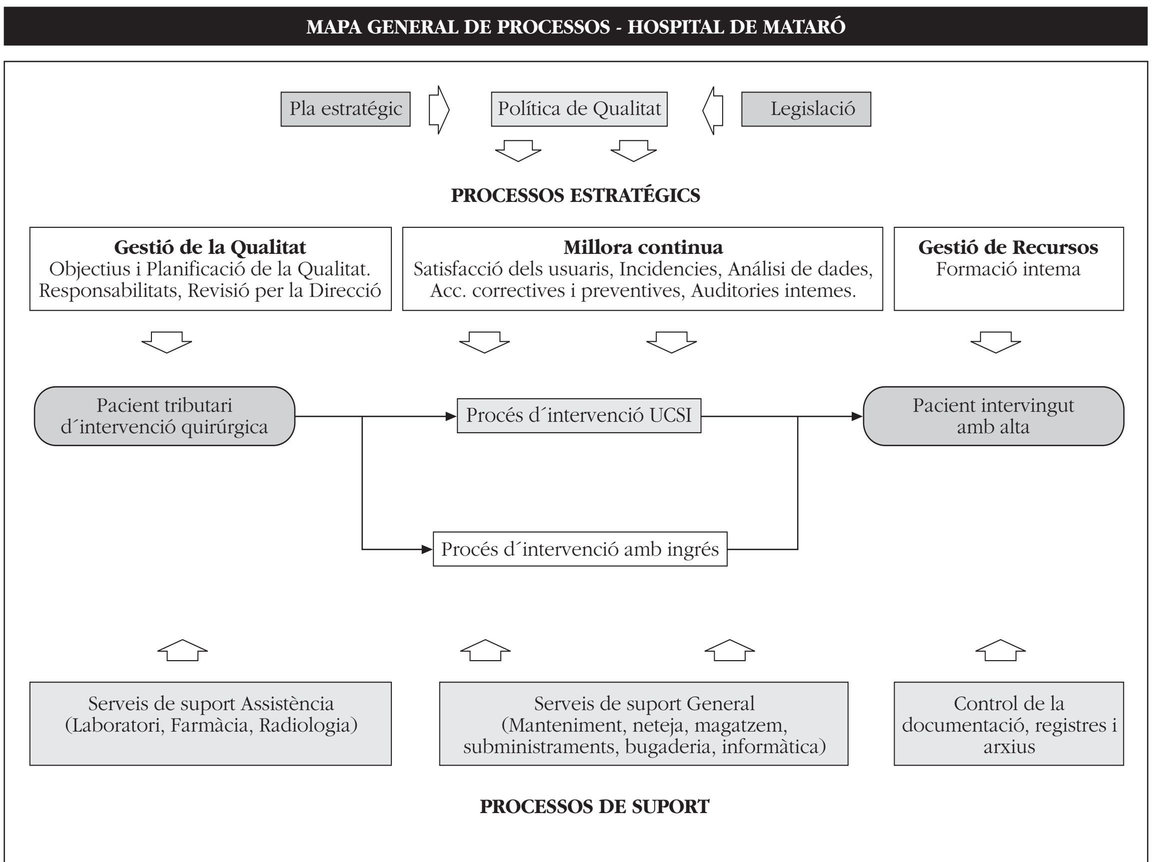
INTER. UCSI	390	1202	1639	1816	1963	2197	2977	3175	3469	3536	4375	26739
INTER. HOSP.	1408	3298	2847	3037	3018	2986	2952	2804	2710	2528	2463	30051
TOTAL INT. PROG.	1798	4500	4486	4853	4981	5183	5929	5979	6179	6064	6838	56790
DESPROGRAMACIÓ											169	
% DESPROGRAMACIÓ											3,86	
SUSPENSIONS	2	23	37	46	35	57	32	47	61	50	83	473
% SUSPENSIONS	0,51	1,91	2,26	2,53	1,78	2,59	1,04	1,48	1,76	1,41	1,90	1,77
REANIMACIÓ>90MN.										72	69	
% REANIMACIÓ>90MN.										3,61	1,58	
TRUCADES	4	61	118	88	58	88	93	88	99	142	125	964
% TRUCADES	1,03	5,07	7,20	4,85	2,95	4,01	3,12	2,77	2,85	4,02	2,86	3,61
VISIT. URG.										98	170	
% VISIT. URG.										2,77	3,89	

(102 min.) and early admissions (1.3%).
- Postoperative follow-up: reoperations (0.25%), emergency evaluations (2.7%), outpatient evaluations (1.6%), late admissions (0.2%), postoperative pain under 3 measured by analogical scale of pain (5.2%) and analysis of satisfaction questionnaire of the patients.

CONCLUSIONS

The challenge for the first decade of 21th cen-





tury of Major Ambulatory Surgery in spain is quality management with 2 central points.

- To achieve a wide consensus about quality indicators and how to be monitored.
- The system of quality management adaptation to ISO 9001/2000 norm.

Both central points will allow us the continuous improvement of quality in the units but an objective comparison between them.

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AMBULATORY SURGERY: THE INDIAN PERSPECTIVE

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INTRODUCTION

Medical and health care in India have two parallel systems: the public sector and the private sector. The former caters to a larger population and is almost free, but lacks in funding and personnel. The private sector, which serves a small urban population, is at par with the best know-how and equipment available in the world, but is expensive. Only 17 per cent of all health care expenditure in India is borne by the government, making it one of the most privatised health care systems in the world.

Of the total population of 986,099,000 (nearly a billion) in India, 73.87% live in the villages and smaller towns, some of which are accessible only by foot. The rest 26.13% only reside in the cities.

A national census and detailed statistics of the surgical patients attending the OPDs and being operated upon has not yet been compiled by the government or any private agency.

The Western region of India, where the city of Mumbai is situated, drains a large number of patients from all over the country and therefore, has been taken as a 'Sample' for compilation and presentation. In addition to its 20 million resident population and several million floating population, Mumbai caters to nearly 40% of patients from all over the country. Some of the best equipped Public as well as Private Hospitals are situated in Mumbai.

HISTORY

Shushrut, the great Ayurvedacharya of ancient India, has documented surgeries in his compilation, more than 2000 years ago, which were based on the concept of modern day Ambulatory surgery. Modern medicine has rekindled the interest in Ambulatory surgery and the last century has seen a gradual rise in its development.

MATERIAL AND METHOD

Statistics have been taken from 3 leading Public hospitals and 2 Private Hospital, which are the largest in the country. Their total bed strength is about 5855 and they cater to approximately 1.5 million patients every year. Surgical OPD attendance is 500,654 patients including all surgical specialities combined. Of these patients, 167,222 underwent surgical procedures during the year 2003-2004.

The number of Day Surgery cases, including OPD procedures, was 77,578, that is, 46.39%.

Most of the hospitals perform Day surgery as part of the regular surgical list. According to the latest government estimates, the doctor-patient ratio is 1:1800 and the hospital bed-patient ratio of 1:1123. There is an estimated shortage of 42,000 beds in just the government hospitals which cater to 60% of the population.

The criteria's for patient selection and preparation remain similar to those followed all over the world with a few variations to suit the local needs.

DISCUSSION

The sheer size of the population and lack of funds have made Heath care more and more dependent on Private sector which is sometimes out of bound to the poor patient.

In a recent study, the expenditure as percent of the GDP, from 175 countries shows:

India to be spending 0.9% in the Public sector, 4.2% in the Private sector, totalling 5.1% of the GDP. Whereas, the USA spends 6.2% in the Public sector and 7.7% in the Private sector, totalling to 13.9% of its GDP. India stands 171st in expenditure on its Public health care system. In contrast with the rank of 18th in the world, in terms of expenditure in the Private Health Care sector.

Amongst all the surgical specialities, less than 15% of cases operated upon are true Day Cases. The bulk of these patients come from the specialities of Ophthalmology and ENT, followed by Gynaecology and General surgery. The other super-specialities only contribute a very small fraction.

As far as National programme and policy making is concerned, the government agencies have been over-burdened by the epidemics and pandemics of AIDS, Malaria, Kala Azar, Polio and malnutrition, thereby completely sidelining the surgical specialities.

The problems faced in India by the Day Surgery programme are: lack of awareness in the patient population and poor facilities for training doctors in this specialty. As you will realise from the number of Day Cases being performed in our country: 75% of the cases are minor or OPD procedures.

The Indian Association of Day Surgery was conceptualised 2 years ago by a few like minded surgeons, who were interested in day surgery. They got together with the sole purpose of furthering the concept of day surgery in the country by increasing the awareness among the patients, creating training facilities for the surgeons and working with government agencies to help them make policies which will be beneficial to all.

Paucity of funds has been the main deterrent in achieving your goals, but it is hoped that the perseverance and devotion of a few dedicated surgeons will extensively establish Ambulatory surgery in India.

CONCLUSION

A developing nation like India, with a large part of its population living below the poverty line, would benefit tremendously by popularising the concept of Day surgery. There is little doubt that, like anywhere in the world, Day surgery will be the Future of Modern Surgery in India too.

PARALLEL SESSION 1

AMBULATORY SURGERY QUALITY IMPROVEMENT

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CQI. PATIENTS AND PROFESSIONALS PERCEPTION OF DAY SURGERY

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"La mejora continua" es una pequeña frase que encierra un gran significado para la labor diaria de los profesionales sanitarios. Efectivamente es necesario mejorar continuamente para satisfacer las necesidades y expectativas de nuestros pacientes y para nuestra propia realización personal y profesional, como sanitarios.

La importante revolución que ha supuesto la CMA en el abordaje de determinados problemas quirúrgicos, está produciendo un importantísimo efecto en la distribución de recursos y en la percepción que los pacientes y familiares tienen ante un proceso de esta naturaleza. En dicho proceso, el protagonismo reside en dos actores fundamentales e imprescindibles, los pacientes y los profesionales que les atienden. Para mejorar, dentro de un sistema de gestión de la calidad, no podemos obviar las opiniones que unos y otros tienen sobre la Unidad y su actividad, y por tanto el nivel de satisfacción que tanto los pacientes como los profesionales presentan en relación con la misma.

Por ello es necesario establecer métodos de evaluación de la satisfacción de ambos actores. Los resultados nos permitirán profundizar en el proceso de mejora continua de la asistencia que prestamos en nuestra Unidad, unidos a otras herramientas de mejora de la calidad.

Vamos, por tanto, a analizar algunos aspectos básicos que pueden ayudarnos a conocer cual es la percepción, que de la UCMA, tienen de un lado los pacientes y de otro los profesionales que en ella trabajan.

1. Evaluar la satisfacción de los pacientes.

Un principio de calidad mundialmente aceptado y perfectamente válido en el sector sanitario, nos dice que el cliente es quien debe establecer el nivel de calidad de los productos o servicios, y que eso siempre lo hace en función del grado de satisfacción obtenido en el cumplimiento de sus necesidades y expectativas. De ahí que exista calidad si el cliente lo dice y el grado de calidad alcanzado es el que el cliente manifiesta. La satisfacción del cliente debe conseguirse en todas las facetas que pueda llegar a percibir, no deriva solo del resultado final alcanzado puesto que un solo fallo en la cadena puede hacer percibir una mala calidad en la prestación del servicio recibido, y el no cumplimiento del objetivo perseguido por la calidad.

En la Unidad de Cirugía Mayor Ambulatoria el cliente es el enfermo o paciente, y las premisas antes manifestadas mantienen todo su valor. Una magnífica cirugía aplicada al paciente con un resultado extraordinario en cuanto a la curación del mismo, puede ser percibida como un auténtico desastre si en el trascurso de la atención recibida algún factor, que no tiene porque ser estrictamente sanitario, ha producido la sensación en el paciente de fallo en la organización y que la asistencia recibida, en su conjunto, deja algo o mucho que desear.

Cuando procedamos a medir o evaluar la satisfacción de los pacientes, debemos establecer una serie de variables o parámetros relacionados con los diversos aspectos que el paciente puede detectar y que para los responsables de calidad de la UCMA sean fáciles de medir. Estos suelen coincidir con los motivos de queja mas habitualmente recogidos.

- Variables o parámetros cuantitativos relacionados con el acceso a los servicios sanitarios.
  - Tiempos de espera o demoras en la cita previa.
  - Tiempos de espera o demoras en la admisión o retrasos en las pruebas.
  - Anulaciones de citas.
  - Continuidad de los cuidados.
- Variables o parámetros cualitativos relacionados con el diagnóstico y el tratamiento.