

## **“Making Day Surgery Work”**

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Success in Day Surgery has various definitions depending on where you stand. For some centres it's purely business; patient fees minus cost-of-doing work, equals profit. More profit means more success.

For most practitioners and health managers however, success is more accurately portrayed in measures that reflect an effective reduction in the burden of disease.

For the patient, success is simply a procedure that went well.

Anaesthesia for Day Surgery is no longer a new subspecialty. Many procedures are now almost exclusively performed on an outpatient basis, with the overall figure hovering around 65% of all procedures (allowing for some major differences between countries).

The majority of currently practicing anaesthetists will be exposed on a daily basis to same-day patients across a wide variety of healthcare settings. The generic components of providing care in these environments are well-described in most anaesthesia texts. These include Unit design, staffing, patient selection and choice of anaesthesia technique. In addition, ANZCA has a number of guidelines promoting safe practice in day surgery, many of which will be familiar.

My intention in this presentation is to focus on key managerial and organisational aspects that I feel have a strong influence on the quality of the day surgery service we seek to offer. We have an obligation to utilise health resources efficiently, and all of us are involved in this process. Being a “teaching hospital” is no excuse for underperformance.

Largely I will be passing on my observations and thoughts on some of the myriad inefficiencies that can invade your Day Surgery Unit. Where available, I will attempt to produce data to support my opinions, but applying costing figures originating in one Unit to other institutions is not always appropriate or even necessary.

### **Key Points:**

Doctors are not necessarily the best leaders of Ambulatory Centres and nurses are definitely not the best managers.

Pushing the envelope and constantly expanding the basket of cases suitable for Day Surgery is likely to compromise your efficiency rather than improve your funding.

Trainees in anaesthesia and surgery need to be incorporated into your Unit in a manner that doesn't compromise the primary purpose.

Understanding and appreciating the difference between processes that can be directed by protocol, and those requiring clinical discretion, is vital if bottlenecks and conflict are to be minimised.

In the clinical environment there will inevitably be an unexpected adverse event. Avoiding a witch-hunt in the aftermath is vital to ensuring solid long-term performance.

### **References:**

Pink, Daniel H “Drive” Riverhead Hardcover, 2009

Steele, S et al, “Ambulatory Anesthesia and Perioperative Analgesia” McGraw-Hill, 2007