4b. CHOICE OF LOCATION

The current arrangements for children's day case services are generally unsatisfactory. In their evidence many hospital staff are critical of their hospital's performance, though at the same time they cite examples of excellent practice in small areas. Problems include a lack of co-ordinated policy, an apparent inability to plan when a diverse group of clinicians and managers is involved, inadequate understanding that day cases have different needs from inpatients and an absence of clear objectives and operational guidelines.

To help in future planning we present 12 quality standards which are laid out at the front of the report on page 6. They result from an analysis of existing practice, amalgamated with professional wisdom and tempered by the comments of parents. The implementation and monitoring of these 12 quality standards should produce an effective and efficient service for children. The CCHS Committee believes that they are all attainable in an "average" district general hospital. We also believe that there are various ways to achieve them, depending on local circumstances.

The fundamental question is **where to locate the service.** Evidence presented to the CCHS Committee shows that the issue is likely to be fraught with dilemmas. The advantages and disadvantages of the patterns observed or reported to us are discussed below. Much will depend on the **actual and potential number of children** who can be gathered together. This is discussed first.

FIRST FIND THE CHILDREN

A client group

Are all children (0-16 years) planned for as a client group? If so, the boundaries of the day case programme should be set wide to include surgical intervention, medical therapy, tests and investigations and nursing care.

Child population and age distribution

What is the child population of the catchment served by the hospital, both the number of children below the statutory minimum school-leaving age (0-16 years) and the number under the age of 5? The latter figure is particularly important on account of the skewed distribution of child patients; half of paediatric medical patients and 60% of paediatric day surgical patients are under 5 (Atwell and Gow 1985; Thornes 1987).

Current number of day cases and ward attenders

How many children (0-16 years) are admitted currently as day cases? Do the data appear likely, or are many day cases being missed? (Thornes 1988; Hayhurst 1988). How many ward attenders are there?

Change from inpatients to day patients

Does a breakdown by specialty suggest that some consultants have not moved from inpatient to day case management (Bates and Hamm 1989; Gabbay and Francis 1988)? A recent survey (Part 1a page 2) reveals surprisingly low percentages for several of the commoner procedures. Would the consultants be willing to change their method of management if special day facilities for children were provided? Clearly each consultant needs to consider each patient's needs individually, but there is considerable scope for change.

Gathering children together

Where are children admitted at present for day case services? Are all children's services, medical and surgical, centralised in one hospital in line with government recommendations (Department of Health 1991)? Except in the smallest districts, such units in district general hospitals are likely to have considerable numbers of day cases and a special children's day ward should be set up. East Suffolk and Southampton have such wards and several other districts have one planned.

Change of location for day surgery

Conversely if a comprehensive unit has not been achieved, there may be consultant surgeons, for example in ophthalmology, ENT and orthopaedics, who admit children to adult specialist wards. Surgeons from these specialties may have already started to admit children for day case operations to adult day units, which now exist in most districts (Audit Commission 1990). Would these consultants be willing to change the place of admission if special children's day facilities were provided?

Imaging

The radiology department also sees increasing numbers of children. Children more often than adults need admission beforehand to a ward for sedation, general anaesthesia or catheterisation before investigations. Skilled observation, preferably by paediatric nurses (Part 1b) is also needed following the procedure.

Equipment-dependent day treatment

There might also be well-established day services in other parts of the hospital for particular procedures such as kidney dialysis, which is probably dependent on equipment that cannot be duplicated.

The effect of new technology

As new techniques for diagnosis and treatment develop, the potential numbers of children suitable for day admission will change. One example brought to our attention was pulsed dye laser treatment of portwine stain birthmarks.

The effect of recent changes in the organisation of the NHS

Referral patterns may change as the contracting system develops. Health authorities and budget-holding general practices, as purchasers, may be able to influence the clinical practice by specifying at the contract stages the expected mode of treatment, and by detailing quality standards of care. Since "money will follow the patients", more efficient or more caring units may attract more child patients.

CHOICE OF LOCATION - CLEAR CUT OR COMBINATION?

There is a basic issue to thrash out. Is the day case service to be based on all children being kept together? Alternatively, if this cannot be achieved, can the surgical and medical cases be separated and children still be treated as children?

This is an extreme simplification of the issue, but it provides a framework for presentation of the options.

SYSTEM I: KEEP THE CHILDREN TOGETHER

There are two patterns, both based on the children's department.

Pattern 1: A children's day unit

This must be near the theatre or have an integrated theatre and be planned for both surgical intervention and medical treatment.

Advantages

- The day unit is managed within the paediatric department and shares its philosophy.
- Children are not admitted alongside adults.
- Day patients are kept separate from acutely ill patients.
- The day unit has its own staff so that pressures on staff shared with inpatients do not arise.
- Paediatric nurses are employed.
- A children's day unit is a good environment for paediatric nurses returning to work after a career break (Part 5a section 12 (iii)).
- A children's day unit provides a good training ground for student nurses.
- The environment is designed for children and their families.
- Safety standards for children are incorporated in the design.
- The staff build up an expertise in day case work and design a patient management system for ambulatory care, so that every child is likely to be discharged within the day.
- Play staff are available.
- The administrative and clerical system is geared to short stay and speedy transfer of care.
- Parents prefer a situation where they can concentrate on their own child's needs and not be drawn into inpatient activities.
- Children, and parents too, prefer to be with other children "in the same situation as themselves."

Disadvantages

- Nursing staff may feel that day case work is less interesting.
- Taking day cases away from the inpatient wards leaves only patients with greater dependency, which may be more stressful for the staff.

How to make the best of this pattern

- The CCHS Committee believes that this is unquestionably the ideal pattern if numbers of children are sufficient.
- Ward attenders can also be seen on the day ward and this increases the use of the unit, reduces overcrowding in the inpatient wards and separates healthy children from the acutely ill.
- Some hospitals have also found that the consultation or treatment room on the day unit is ideal for child abuse examinations.

Pattern 2: use of the children's inpatient ward

Our evidence suggested that two-thirds of districts admit all child day patients to the children's inpatient wards. Both parents and staff had valid criticisms of the quality of day case management in many hospitals, where day patients are treated as a minor type of inpatient, slightly less important and certainly more rushed. However, we have also received evidence of efficient day case services on inpatient units.

Advantages

- The philosophy is child-centred.
- The surroundings are designed with children in mind.

- The parents' facilities, such as lounge and kitchen, can be used.
- If the child is not ready for discharge at the end of the day, the family can stay in the same ward, with minimum disruption, but this should be a rare occurrence.
- The nurses are qualified in sick children's nursing.
- Play staff are available.

Disadvantages

- Children who are basically healthy are mixed with acutely ill inpatients.
- Day cases can become "second class patients" on wards where staff have duties to both inpatients and day cases and have to make a choice. One sister described them as "lodgers". This concern was voiced by doctors, nurses and parents.

"I had no idea what would happen - my fault that I didn't ask - but the ward was very busy and understaffed and you feel that grommets aren't that important compared with the injuries and illnesses other children were in for."

- A long distance between the children's ward and the theatre can influence the willingness to use the ward for surgical day cases, since the quality of care can be compromised. Anaesthetists have firmly stressed this point since they need to see each child and parent pre-operatively. Once the list has started a long distance may preclude a visit; or the children may have to be called to the hospital hours in advance of the operation, so they can all be seen by the anaesthetist in a group.
- Not enough thought has been given to the different needs of day cases and there is an assumption that inpatient information and protocols are adequate. For example: on written information:

"Most of the booklet they sent me was quite irrelevant. I couldn't find anything in it that answered my particular problems."

on documentation:

"They asked all the same questions as when my other girl was admitted for a two week stay - about what she liked to eat and her daily routine - it was ridiculous."

on management of waiting time:

"We got to the ward at 7.30 as requested. There was no-one on the ward clerk's desk and so we wandered down the ward until we found a nurse who told us to go to the day room. We waited there for at least an hour and a half during which no-one came near us."

on communication:

"Although no-one told me about going home, about 9pm I presumed they wouldn't turn us out, so I rang home to let them know. I settled in an easy armchair near his bed so he could see me. About 11pm a nurse noticed me and brought me a put-u-up bed."

- Parents resent having to become involved with inpatients. *"I felt I had to comfort the child in the next bed whose mother wasn't there (he was an inpatient) but I resented it."*

Day patients nursed in children's inpatient wards are more frequently kept in hospital overnight than those nursed in special day facilities. This is a waste of resources.

How to make the best of this pattern

- The CCHS Committee recognises that day admission to a children's inpatient ward is not ideal. However, with a major change in attitudes, planning and management, it could provide acceptable care. It is vital that the 12 quality standards (Part 2b) and the 42 principles (Part 2c) are adhered to.
- Two issues need urgent attention: the establishment of a separate area of the ward for day patients and the designation of specific staff to the day case area. By these means the day patients will be seen as a distinct group and the staff will be aware of their status, and work towards the successful completion of the admission in the day. Separate protocols for the management of day patients and parents' information should be developed. Nurses need the opportunity to study a good day case programme in action, so that they are confident in adapting their care plans for day patients. Many practical ideas, covering these and other issues, appear in Part 5.
- It may be feasible to use the designated day area for evening leisure facilities, either for parents or older children. It could also double up as parents' accommodation at night - not ideal, but better than many current arrangements.
- If the distance between the children's ward and theatre is too great, consideration should be given to whether the ward is a suitable location for surgical day patients, since the essence of surgical day case management is simplicity and short stay. Some wards have reported problems with logistics and these are discussed in Part 5a section 1(i). Because of the difficulties of throughput, a few hospitals have established paediatric holding rooms in the theatre suite with suitable entertainment and diversion for children who are still alert. No doubt this is an improvement on previous practices, but the underlying problem - that this ward and theatre combination is not ideal for day surgery - remain.

SYSTEM II: SEPARATE SURGERY & MEDICINE

Again two major patterns have emerged from the evidence submitted to the Committee.

Pattern 3: children's day room (basically medical procedures)

Several hospitals have a simple type of children's day room, where medical procedures and preparation for diagnostic testing (for both paediatricians and surgeons) take place, but other surgery is not undertaken. Ward attenders are also treated here. These rooms are usually attached to the inpatient ward or occasionally to the children's outpatient department, where one exists. They appear to work extremely well and certainly are successful in reducing noise and movement in the main part of the inpatient ward.

Advantages

- These are identical to those for Pattern 1, a full children's day unit. Please refer to page 17.

Disadvantages

- The major disadvantage is that most day surgery, except perhaps for diagnostic procedures such as endoscopies, is excluded. So the problem of the location of day surgery remains unsolved.

How to make the best of this pattern

- If space allowed, a day room could be expanded to include a recovery area for children following surgery, so that it would develop into a Pattern 1 or 2 service. One hospital that tried this pattern with two surgical beds warns that this was not viable. Four or six beds would be a better number for staffing purposes, and so it is important to involve as many surgeons as possible in their use.
- This pattern is sometimes combined with the surgical children being nursed on the inpatient ward. All the disadvantages listed above in Pattern 2 must be considered.
- An alternative combination is for surgical children to be nursed in adult day units. See below (Pattern 4) for advantages and disadvantages.

Pattern 4: use of adult day units

Currently young children are admitted to few adult day units. Paediatricians, paediatric nurses and managers of children's services feel that the environment, staffing and facilities are not suitable for children, and do not meet government recommendations (Department of Health 1991; NAWCH 1984). However, children in the 11 to 16 age group are commonly admitted and some hospitals are possibly considering the establishment of day units which will admit both children and adults. This is a difficult concept and will require co-operation and careful planning. It should also be remembered that adult day units, although they may admit adults for some medical procedures, generally deal only with routine surgical operations for children, so that children's investigations and medical treatment still have to be located elsewhere.

Advantages

- The day routines are better developed and the child undergoing surgery is far more likely to be discharged the same day than from an inpatient ward.
- It is easier for the anaesthetist to visit in order to check fitness for anaesthesia and to prepare patient and parent if all the patients for the list are on the same ward. Since most surgeons currently arrange mixed lists of adults and children, this is most likely to happen on an adult day unit.
- If the unit is integrated with the theatre, it is possible for the anaesthetist to come to the ward between patients, even when the operating list has started. If the unit is integrated with the theatre and if there is a list dedicated to day patients, there is a much greater chance that doctors from both the surgical and anaesthetic teams will come to the unit to talk to the parent and see the child post-operatively.
- Day cases are separated from acutely ill patients.

Disadvantages

- Children are frequently nursed side by side with adults in the recovery area on the ward. This situation is quite unacceptable. It has been government policy since 1959 that the practice should be abolished.
- The nurses are rarely appropriately trained to nurse children. The skills of nursing young children, involving the parents whenever possible, preparation and communication with both parent and child are essential. Some adult units have suggested that because the parent is present throughout the day, the need for a nurse appropriately trained in the care of sick children is less. We believe that this view misjudges a parent's need for information and support.
- It reduces the opportunities for student nurse education since the English National Board for Nursing, Midwifery and Health Visiting does

not accept wards that admit both children and adults together as suitable for nurse education/ training.

- The clinical safety of children, including such items as paediatric resuscitation equipment and drugs in suitable dosages, has not always been considered.
- Documentation for use during the day is usually oriented to adult patients.
- The decoration, colour schemes, pictures and the environment in general are not designed for children. A child-centred environment aims to be homely, to divert attention and to reduce stress.
- The equipment and facilities are rarely geared for young children and families. This includes such items as small lavatories or potties for toddlers, nappy-changing facilities, facilities for preparing bottles and toddlers' feeding cups.
- The physical safety of active children has not always been considered. The location of electric sockets, guards on radiators, child-proof doors, cot sides and beds without a lever mechanism are a few examples (appendix IV).
- Usually there are no play staff and so there is no organised play and recreation, active management of the waiting period or play preparation.
- There is rarely a separate play area where children can be active without annoying adults.

How to make the best of this pattern

- We have observed three models for the management of young children admitted to adult day units for surgery.

  Model A The most common model is for children to form a small part of one surgeon's list and they are admitted together with adult patients. This is an unacceptable practice. It does not conform to the 12 quality standards and we reject it. Some hospitals exclude very young children (especially those under four years of age) who are admitted to the children's wards, where facilities are better and staff more suitably trained. We feel that this does not go far enough, since all children need good facilities and paediatric staff.

  Model B In a second group, a periodic or occasional children's day list is built up, so that the children do not have to be nursed alongside adults. This happens in Winchester and Exeter and children under the age of four years are also admitted. We recognise that this pattern may enable the hospital to conform to the 12 quality standards. Surgeons need to agree to build up a children's list and an anaesthetist skilled in work with children should be involved. The unit needs to be converted into a children's ward for the session and the provision of token toys is insufficient. Appropriately trained nurses and play specialists should be brought in, so that the children's ward philosophy is also transferred.

  Such a system can combine the best of a day system with a child-centred service. The organisation is critical and evidence suggests that the maintenance of standards needs constant vigilance and enthusiasm. Flexibility may also be needed. For instance in Exeter a system has been agreed whereby the day unit is used when there is a full list of eight children. The unit is transformed into a children's unit for the session and there is an agreement that a paediatric sister will be employed. The system enables the anaesthetists to visit each child individually pre-operatively and the surgeons to come out of theatre to discuss the outcome with parents. This would be impracticable if the children were in the children's ward because of the distance from the theatre. An occasional child on an operating list for day surgery is still admitted to the children's ward.

  Model C A third model is to admit a small group of children into a special room, where they can be active and later can recover separately from the adult patients. Kingston and Colchester are currently using their facilities in this way. In Colchester there is an agreement that an appropriately trained nurse will be on duty when children are admitted. With careful planning this pattern, too, could conform to the 12 quality standards.

- It should be remembered that a decision to use an adult surgical unit is only half a solution, since medical patients still have to be accommodated. It is probably best combined with a children's day room attached to the children's ward or to the children's outpatient department.

SUMMARY

The best option is a children's day unit admitting both medical and surgical patients.

If this is not viable, the other possibilities are:

For all children A day area in the children's inpatient ward.

For medical procedures A children's day room (in combination with a bay for surgical patients in the children's ward or sessions in the adult day unit, Model B or C).

For surgical procedures Sessions in the adult day unit, Model B or C (in combination with a day area or day room for medical patients).

Wherever the children's day services are located, we recommend that the hospital adopts the concept of a planned package of care that will accompany each child. This is given in Part 2b.

Part 5

Delivery of day case services

5a. SETTING UP A CHILDREN'S DAY CASE PROGRAMME: TURNING THE 42 PRINCIPLES INTO PRACTICE

The first 42 principles listed in the recommendations (Part 2c) form a framework for an ideal children's day programme that stretches from the outpatient appointment to after-care at home. This framework can be expanded in several ways. Firstly the principles can be turned simply into policies. Secondly they can be translated easily into detailed standards, so that the quality of the service can be monitored. Thirdly they can also be expanded into operational guidelines to turn policies into practice.

The latter is the subject of this chapter. We present explanations, comments and discussion for each of the 42 principles. The practical advice and innovative ideas have all been taken from the evidence sent to CCHS by parents, consumer organisations and health service staff who are currently running day units or working with child day patients.

As part of this day case service, we describe a children's day unit that admits children for medical and surgical procedures and diagnosis. In an ideal world it would have an integrated day theatre, but it is more likely that a central theatre suite will be used and this is the situation outlined. Since the theatre suite is likely to be under different management, policies for that part of a child's admission are separated out and presented in Part 5b.

It is hoped that the suggestions will be helpful for all managers who are establishing operational guidelines for their day programmes. Many of the ideas could be introduced in any district, whether it has a purpose-built day unit for children or runs a day programme based on inpatient wards or on an adult surgical unit.

ENVIRONMENT

This section includes site, design, layout, equipment and facilities.

1. **The site of the unit, in relation to the children's inpatient facilities and the operating theatre, should be determined by local circumstances. Any conflicting requirements of anaesthetists, surgeons, paediatricians and others should be considered in terms of the best interests of the child and family.**

(i) If your hospital has identified sufficient children and has agreed to set up a children's day unit, the first very difficult question may be where to locate it. There is no easy answer. In a children's hospital it should be as close as possible to the theatre, and on balance this is also likely to be the best place in a District General Hospital. Even though the unit will be used by medical as well as surgical cases, easy access to the operating theatre remains a major consideration. A short distance will facilitate the throughput on a list of short operations, simplify the journey for children who are walking or being carried by parents or a nurse and reduce porterage time back to the ward. Anaesthetists need to come to the day ward to see children pre-operatively and also prior to discharge if there is no central recovery unit; if the time taken to walk between the theatre and ward is too long, safety may be compromised and quality of care may suffer.

(ii) It should have easy access to the X-Ray department, or at least good signposting, since a considerable number of patients will be moving between the unit and the X-Ray department for imaging or other tests.

(iii) The following are some of the issues that might be discussed in canvassing the opinions of all who are likely to use the unit.

- Are there problems of the unit being included within the management structure of the comprehensive children's department if it is physically separate?
- What proportion of the children will be having surgery or tests involving a visit to the operating theatre?
- Do surgeons, paediatricians, anaesthetists and other staff who frequently have to move between the unit and other parts of the hospital, have a strong and reasoned preference for one particular site?
- What do the nurses think will be more important for the efficient running of the unit: proximity to the theatre or to the children's ward?

2. The design of the unit should allow the separation of day cases from inpatients.

(i) It should be kept in mind that most children admitted as day patients will be healthy, they will be in hospital for only a few hours and they will be mindful of their stay. They should be kept quite apart from inpatients who are acutely ill and the design of the unit should ensure this.

(ii) The accommodation should ideally include:

- a reception area/play room/discharge area; if possible an area for older children should be separated in some way
- a post-recovery area with room for trolleys/beds and comfortable chairs
- some cubicle accommodation to provide privacy for example for breast feeding
- a unit office which has space for temporary storage of medical records. Maybe waiting lists will be held here and admission letters and instructions dispatched
- a shared sisters' and doctors' office
- a separate nurses' station
- a consultation room
- a treatment/examination room
- clean and dirty utilities, linen and supply stores
- equipment store, staff locker room and cleaners' room
- a pantry to make drinks
- lavatories for patients, parents and staff.

3. The layout of the unit should reflect the fact that children arriving for elective procedures are generally in good health and require neither a bed nor a trolley in the early stages of their admission.

(i) Unlike inpatient wards, a day unit does not function around beds (section 32(i)). Ideally the recovery area should be separate. Failing this, any beds, cots or trolleys should not be immediately visible to children on arrival. Instead the family should be given a special named locker with space to hang outdoor clothes. The concept of a child needing his own territory is not valid for such a short stay and when a parent is present the whole time.

(ii) The reception/play/discharge area should be central and large so that it can form a hub for most of the activities. Ideally the reception entrance should not double as exit to the theatre suite. A good system is for surgical children to move round the unit in a loop, leaving for the theatre suite by a separate entrance and returning to the post-recovery area without passing through the play/waiting area. It is easier to achieve this in a square unit than in a long, thin ward.

4. Child-proof fittings, furniture, equipment and storage should be installed to reduce the likelihood of danger to active children.

Advice on safety has been gathered from various sources and appears in Appendix IV. Some nurses have queried the use of trolleys as a replacement for beds in the post-recovery area. Members of the Committee have seen trolleys in use in several day units and no safety problems have been reported. Children need to lie down for a while after return to the unit, but they always have a parent alongside. Younger children are usually happier in their parent's arms. With modern methods of anaesthetic care, children become mobile very quickly and this stage is often very short.

5. The unit should be decorated, furnished and equipped to provide a cheerful and homely environment for children.

(i) Children arrive in an observant state and remain alert for most of the admission. It is essential that the surroundings are friendly and designed with children in mind. Homely decorations are important, as well as child-sized equipment and facilities for changing nappies, preparing bottles and toddler feeding cups. Older children and teenagers should not be forgotten and the decorations should not concentrate solely on "nursery" pictures. If the children's day unit is part of the comprehensive children's department it is likely that this sort of environment will be easy to achieve. Members of the CCHS Committee have noted on visits that wards where play staff are employed are often brighter and more attractive.

(ii) Evidence suggests that, once back at home, children describe the toys they have played with when asked about the day. Much of a child's wakeful time will be spent playing and good quality toys and games, chosen for a range of ages, should be available. Booth Hall Children's Hospital has a snooker table that is popular with older children and teenage girls enjoy a selection of magazines.

6. Facilities should be provided to meet the needs of parents who will be at least as numerous as the children.

(i) Comfortable chairs should be provided for parents, not only in the play and waiting areas, but also in the bed/trolley recovery area. Some day units provide rocking chairs as part of their recovery area.

(ii) A public telephone should be easily accessible to the unit.

(iii) Ways of providing parents with a drink or snack should be considered.

7. The unit should be equipped to ensure the clinical safety of patients following a general anaesthetic. The type of equipment should depend on the facilities provided in a central recovery unit.

(i) If the hospital has a central recovery unit where children stay for a minimum period, commonly 30 minutes (McConachie et al 1989), further recovery facilities are not required on the day ward, except for those that are provided on every ward as a matter of course. The same is true for an emergency call system.

(ii) If basic post-operative recovery takes place on the day ward, medical gases (oxygen and suction) should be provided in all trolley spaces and nurse call facilities should be available.

8. The treatment room should be fitted with appropriate sized equipment to carry out biopsies, chemotherapy, plaster work and other procedures done on a day basis. If general anaesthesia is to be administered in this treatment room, it should be fully equipped to the standard expected in operating theatres.

The administration of general anaesthesia for investigations and medical therapy in treatment rooms on the wards is a separate issue. Many anaesthetists believe that it would be safer for these children to go to the theatre, if it is close enough. If these procedures are to be done on the ward, the treatment room must be fully equipped for general anaesthesia to theatre standards, including the scavenging of gases. The provision of basic resuscitation equipment is essential in the recovery area, since the first stage of recovery will take place there.

9. A telephone with a direct outside line should be available for fast communication between the unit, primary and community services and patients' homes.

See sections 22(iii) and 25(vi).

STAFF

This section covers the people needed to direct, manage and staff the day case service.

10. A director should be designated for the day case service to identify the limitations, translate the objectives into policies and monitor the service.

This person is likely to be a clinician, either a nurse or a doctor.

11. A day unit manager should be appointed to have responsibility for the day-to-day administration of the unit. This should include the number and skill mix of nursing staff and co-ordination with other departments of the hospital and the community services.

(i) This is a key role, likely to be filled by an enthusiastic charge nurse or sister.

(ii) The rapid throughput of patients means that there is little spare time during the day to allow for any margin of error. The nursing staffs' ability to work calmly and ensure that parents are competent and confident is very important; adequate staffing levels and skill mix will help in the development of an efficient and caring service.

12. Nursing staff trained in the care of sick children should be specifically designated to the day case service.

Evidence has been received from many sources that day patients, both medical and surgical, tend to receive less attention than inpatients when staff have responsibilities to both groups and are obliged to decide on priorities. This is true of both nurses and doctors.

(i) The day patients should have a distinct nursing staff, separate from inpatients.

(ii) The employment of nurses appropriately trained in the care of sick children is essential (Part 1b). Much of the success of the day and follow-up care will depend on the participation of parents, which in turn my well depend on the skill of the nurses in preparation and communication.

(iii) The employment of part-time paediatric nurses may be ideal. Considerable numbers of such nurses are currently not employed in nursing (Hutt 1983). This is a good way to encourage back nurses who have had a career break. Firstly flexible hours, day-time only or maybe part-time, can be arranged to suit nurses with a family commitment. Secondly it can ease nurses gently back into the system, since day patients do not have the complexities of high technology patients nor the emotional component of caring for acutely ill children or those with a severe chronic illness.

Adult day units have reported considerable success in

recruiting general nurses for similar work in adult day units (Ogg 1989a and 1989b; Penn 1989). It is on record that such nurses can build up great commitment to the day unit, especially if a strong sense of team work is nurtured, an orientation programme established and in-service courses on care of day patients encouraged (Ogg 1989b).

13. In a children's outpatient clinic, or one in which the majority of patients are children, nurses trained in the care of sick children should be employed, because of the importance of their educational role with families.

See sections 29(i) and (iv).

14. Health care assistants with appropriate training should be employed to assist the nurses in the day unit.

Nothing further to add, but see section 17(ii).

15. Medical staff should be specifically assigned to be responsible for the care of day patients.

See introduction to section 12. To increase the commitment to day case services the duties of house officers and registrars should be formalised and made more explicit, with regard to both medical and surgical day patients.

16. Play staff should be available to provide a play service for children of all ages.

Play schemes should be provided for all children receiving day treatment (Hogg 1990). Even in a system with stepped arrival times, children requiring venepuncture have a minimum of one hour to wait, to allow the topical anaesthetic cream to work. Children attending for medical procedures or tests may be in hospital all day and have waiting periods or episodes of "dead" time between periods of clinical attention. Play staff ideally should have had a specialist training. They should provide:

- organised activities, so that all waiting time is well managed
- individual attention so that the needs of every patient, whatever their age, are catered for
- a relaxed atmosphere that will help to allay anxieties
- preparation for surgery and other procedures
- follow-up play
- a welcoming environment (section 5)
- help with pre-admission visits (section 31)
- liaison with outpatient clinics
- an input in the preparation of literature for parents (section 25).

17. Clerical staff should be available to handle the large amounts of administrative and clerical work generated in a day unit.

(i) Good clerical help is essential if a day unit is to run efficiently. Day attendances generate a great deal of paper work and telephone communication that needs to be organised quickly. A senior clerical officer should be available to assist the day unit manager in the day to day running of the service, which might include:

- liaison with the general practitioner and health visitor
- sending out appropriate pre-operative information
- assembling case notes and investigation reports pre-operatively
- dealing with oversights and omissions
- preparing identity bracelets
- completing documentation on arrival
- typing and dispatching discharge letters
- making outpatient appointments
- contacting general practitioners to relay messages regarding post-operative care
- telephoning community nurses
- organisation of case notes once the child has left the unit.

(ii) Some hospitals have transformed a nursing auxiliary post into a health care assistant, to carry out the "on-ward" part of the secretary's job. This person can also act as a receptionist and hostess for the parents. Hospitals that have introduced a receptionist system speak very strongly of its success, describing the receptionist as "the pivot of the day unit", whose efficiency and empathy ensures smooth running (Valman 1982).

ORGANISATION OF PATIENT CARE

This section covers interactions and communications that are not part of individual clinical care and institutional routines that are not part of treatment.

18. The children's day unit, regardless of its location, should be part of the comprehensive children's department, sharing its philosophy.

The unit should be within the overall managerial control of the paediatric nurse manager, so that it is included in the general philosophy of the children's department.

19. An advisory committee should represent those immediately concerned and form a permanent link with the primary and community services.

The advisory committee might include surgeons, paediatricians, anaesthetists, representatives of the general practitioners who use the service, community

and hospital nurses, theatre management and consumers, so that all who use the unit have an opportunity to share in its success. The director of the children's day services should chair the committee.

20. The director should hold discussions with the advisory committee to determine the scope of the procedures to be undertaken on a day basis.

(i) A list of agreed procedures should be prepared and circulated to the family health service authority (see Part 4a for a discussion of suitable procedures). A supplementary list of more complicated procedures should be drawn up which, after individual consultation on a case by case basis with the general practitioner, might be performed as day cases. These lists should be reviewed annually.

(ii) Firm commitments to use the unit should be sought and sessions allocated for surgery, oncology etc. Agreements should be made on the use of the unit for radiological procedures that start from the day ward, medical therapies, surgical and medical tests and other procedures that do not fit into sessions.

21. A planned systematic approach for integrated patient care should be developed covering pre-admission, day of admission and post-discharge. The concept of planned transfer of care should be adopted.

(i) The general practitioner should be informed of the proposed procedure and if possible the date of admission. Parents could be asked to inform the general practitioner of the date when they go to get the drug form completed (section 23(v)).

(ii) It would be helpful if a list of the criteria used by consultants in the selection of children for the day programme (see discussion in Part 4a) could be circulated to the family health service authority, so that the general practitioners are aware of problem areas, especially in the case of adverse social factors.

(iii) Any arrangements for after-care, which can be identified before admission, should be initiated as soon as the admission date is agreed, to facilitate work load planning by primary and/or community services.

(iv) The director, together with the advisory committee, should define a specific end point at which the general practitioner resumes full responsibility for the patient.

(v) The director, together with the advisory committee, should decide on the protocols for post-discharge emergencies. The following should be covered:

- the time limit on self-referral back to the hospital
- whether the ward sister is permitted to arrange an ambulance on receipt of an emergency telephone call
- whether the district nurse can refer a child back to the hospital.

(vi) There should be a standard procedure to ensure the availability of a child's notes to staff involved in an emergency readmission and at the follow-up appointment.

(vii) See section 27 for documentation for discharge.

22. The service should be designed for ambulatory care and should not depend on attitudes and practices developed for inpatient treatment.

(i) For liaison with the outpatient department, pre-admission preparation and pre-admission literature for parents, see sections 25, 29, 30 and 31.

(ii) Ideally the day programme should be organised and co-operation arranged with clinical and other departments, so that all necessary pre-operative tests and procedures are done either at the outpatient clinic or on the day of admission, thus reducing the number of visits a child has to make to the hospital.

Some hospitals have developed programmes that involve extra visits for the family; they record that such systems lead to greater efficiency. In one children's hospital, children come on Monday for clinical tests and then are admitted for a Wednesday list. In another hospital, children are admitted on the previous day and then are allowed home for the night. These systems partly overcome the problems of patients not turning up (22.6% in one study of inpatients and day cases) (National Audit Office 1987) and give some time to find replacements. They also allow for slowness in administration and support services.

However, true day admissions, without an earlier assessment visit, do occur in many hospitals and can work well, with good co-operation and management.

(iii) The use of the telephone to check on the health of children due for admission is increasing and can reduce the number of missed appointments as well as ensuring that the family is prepared. The Royal Hospital for Sick Children, Glasgow, for example, has monitored the outcome of their calls and finds the system very successful. The calls are best made by a nurse who can advise on clinical matters and solve problems. Time in the evening should be allowed to contact parents who are working during the day. The CCHS Committee is aware that all families do not

have access to telephones. British Telecom suggests that 87% of households have a telephone, though this information is based on a sample. Different arrangements will have to be made for families without a telephone and several hospitals arrange for them to call the ward. A direct line to the ward is helpful when 'phoning from a coin- or card-operated machine.

(iv) Arrangements should be made for admission as an inpatient to a children's ward of any child (and his parent) who is not ready to leave when the unit closes.

Some units find that nursing staff are willing to co-operate in a flexible approach to closing time, so that children rarely have to be transferred to an inpatient ward, especially if they are likely to be discharged later that evening. In Sheffield Children's and Southampton General Hospitals the afternoon shift may have to stay on until 8.00pm to cover any remaining children, though they are just as likely to be able to leave early. In Ipswich Hospital children for blood transfusion and other treatments may come after school, to prevent too much disruption of their normal lives. The unit normally closes at 7.30pm but sometimes the manager will negotiate with surgeons when they have a long operating list and it will stay open later. If nursing staff decide to work late, to stay with a child who is unwell following surgery, their off-duty rotas are re-arranged accordingly.

23. An efficient booking system should ensure that both the hospital and the family have necessary information and sufficient time to enable them to make preparations.

(i) Because of the responsibilities placed on parents and the shortage of time on the day of admission, the pack of information that is sent to the parents with the booking form is extremely important (section 25). If the central booking office for the hospital sends the information, it will need precise individual information for each child. Systems based in the day unit or the paediatric unit office have been reported as most efficient and sensitive to individual patients.

(ii) The sister/charge nurse or manager of the day unit needs time to make preparations. Clinicians and those who prepare operating lists should inform the day unit of the schedules two weeks in advance. The case notes for booked patients should be sent to the day unit manager at the time the bookings are made. The results of tests should be gathered by the day unit manager and placed with the case notes. This is a good opportunity for the day unit manager to check that all necessary tests have been completed and bring any abnormal results to the referring clinician's attention.

(iii) In general, families should be given two weeks' notice of an admission, so that they can organise time off work and make other arrangements. For an appointment arranged at the outpatient clinic, see section 29(vi).

(iv) The day unit manager, working with medical and nursing staff, should be responsible for the production of a simple *booking letter* giving clear instructions on the following:

- date, time of arrival
- where to report for admission
- time to start starvation or instruction on the number of hours of starvation before admission; the danger of not complying (a short explanation of the need for starvation)
- whether the child should be awakened for a drink
- any samples that should be taken
- a number to telephone in case the instructions are not clear. This number should be available during the evening and be manned by nurses or someone knowledgeable on matters such as starvation.

A general letter designed for adults is not suitable. An example of a letter designed for children appears in Appendix II.

(v) A *drug form* needs to be given to the parent at the outpatient clinic or sent with the booking letter, with a request that it should be taken to the general practitioner for completion.

24. An efficient system of patient management and liaison with other departments should be established, so that children admitted as day cases can normally be discharged within the day.

(i) Timing of pre-operative tests, and advance preparation of the family, are discussed in sections 22(ii), 25, 30 and 31.

(ii) *Arrival times*. Parents complain about being asked to arrive earlier than necessary, so that nothing appears to happen for the first hour or so. This can turn into a period of considerable stress with an irritable child and often a parent also suffering from the effects of starvation (Vessey et al 1990). Stepped arrival times provide a better quality of care and whenever possible individual appointment times should be given. Children attending for medical therapy and radiological tests should certainly be in this category. For children on operating lists the problem is greater and, with current levels of medical staffing and intensive use of the theatres, a stepped booking system might not be feasible. It should be easier in an integrated day unit and is an ideal that should be aimed for.

(iii) The *earliest and latest times* for children's day operations should be agreed with the theatre manager, surgeons or whoever prepares the operating list, to allow time for preparation and post-recovery care, within the wider opening times of the day unit. These may take a little longer than for adults because of the use of topical local anaesthetic cream and also the necessity of ensuring that the parent is clear about her responsibilities.

(iv) Issues concerned with *length of starvation and position on the operating list* should be discussed by nurses, anaesthetists and surgeons, so that the reasoning behind practice is clear and problems that arise on the ward are aired. The following issues have been raised in the evidence received by the Committee.

- What is an ideal length of time for pre-operative procedures and preparation?
- Have parents shown themselves willing to wake a child at 6.00am for a drink?
- Might it be preferable to have children on an early afternoon list? Many families prefer either a very early start because of problems with hungry children or to be on an early afternoon list, so that breakfast can be taken as usual.
- Where on the operating list should babies be put? Babies are often put near the beginning of the list, but it might be might be better for them to have their first feed of the day and be fitted into the middle of the list (Part 5b section 53).

(v) For a comment on delay in relation to mixed operating lists and dedicated day lists, see Part 5b section 53(iii).

(vi) *Condensed nursing and medical documentation* should be developed. Consideration should be given to the sharing of one proforma by doctors and nurses. This is not only to save time but also to prevent parents being asked the same questions twice. An example of shared nurse/doctor documentation appears in Appendix II. It fits on to two sides of an A4 sheet, with separate sections for nurse evaluation and medical assessment. All other sections can be completed by either doctor or nurse, depending on who talks to the family first.

(vii) Some hospitals send parents *history forms* to complete at home and others complete as much as possible at the outpatient appointment. This is an attempt to speed up the admission process. However, a day admission should not be an excuse for cutting the quality of care. It is the house surgeon's or senior house officer's responsibility to ensure that the history and examination are complete and accurate. It should also be remembered that taking a history is also an important part of a junior doctor's training. Both the provision of service and the training needs of junior staff can be met satisfactorily in day case work and there need be no conflict between the two.

(viii) Some parents have complained that the time in hospital has been unnecessarily prolonged, even though they felt quite happy about taking the child home. See section 39 for comments on delegating authority to the nursing staff. The anaesthetist or surgeon should complete any prescription for medication to be taken home before the child leaves the recovery area, so that the ward staff can ensure that everything that has been prescribed is ready to take home.

25. Parents should be encouraged to be present throughout the day of admission. Written information should be available to prepare them for the responsible role they undertake.

The day unit manager, working with medical and nursing colleagues and play staff when appropriate, should be responsible for the production of written information for parents, and for maintaining supplies of the leaflets in the unit. Leaflets should be in simple language and consideration should be given to translating them into the languages of local minority groups. It is useful for copies of instruction and information sheets to be circulated to the family health service authority, so that general practitioners can be made aware of their content.

The following should be available:

(i) A *leaflet covering general issues* about day case admission, a description of the ward and regular procedures, including:

- ward atmosphere and appearance
- ward routines
- the need for parents to plan journeys to and from the hospital including the instruction that two adults are needed if one is driving a car
- preparation of child
- organising the family
- what to bring for child and parent
- where to report and how to get to the ward (map or plan of hospital, highlighting parking, admission location, refreshments)
- role of parent
- pre-operative procedures on the ward (e.g. use of topical local anaesthetic cream, whether premedication is usual if so whether choice of injection or oral medicine is given)
- anaesthetic/theatre/recovery procedures
- post-operative care on the ward

- likely discharge time; what happens if child is not ready
- sources of information and discharge advice
- tips on travelling with a child who has had a general anaesthetic
- facilities for parents and young siblings
- general information about making arrangements for the child to be at home for the few days following the admission
- some idea of how support will be provided once the child has been discharged.

An example of a special booklet for day case children appears in Appendix II.

(ii) Ideally a *separate leaflet for the child* to understand and enjoy. Hospital stories, colouring cards and activity books are all in use and are suitable for younger children. These are usually not appropriate for the older child and thought should be given to devising suitable material for this age group.

Information for children and young people with a long-term illness, who are likely to be attending frequently for day treatment, should not be forgotten. An excellent example is "We can make it" which a group of teenagers receiving treatment at Southampton General Hospital helped to compile (Dutton et al 1989).

(iii) *Information sheets* outlining or detailing procedures, to be sent or given to the families before the admission. Most procedures should be covered. Appendix II contains an example. For surgery these are often combined with the post-operative information sheet described below in 25(v).

(iv) An *outpatient appointment pro-forma.* Alternatively, if no outpatient appointment is deemed necessary, a pro-forma letter stating this.

(v) *Post-operative information sheets* specific to each procedure, covering normal after care, including return to normal activities, and listing common symptoms and signs and their significance and recommended action. All except the most rare procedures should be covered. Appendix II has an example. This advice is sometimes combined with the pre-admission procedure sheet described above in 25(iii).

(vi) A *discharge letter/instruction sheet* advising parents how to obtain help. It should cover the following:

- action in the case of an emergency, within a stated period, including telephone numbers (section 21(iv) and (v))
- action in case non-emergency support is needed
- the name and telephone number of the person who has been alerted in the community.

(vii) Other documentation for day admissions are covered as follows:

- booking letter in section 23(iv)
- drug form in section 23(v)
- history form in section 24(vii).

26. Guidelines should be drawn up for parents who enter the theatre suite.

This is dealt with in Part 5b section 52. See also the recovery room protocol in Appendix II.

27. Efficient administrative and management systems should ensure that discharge notes are given to the parents before they leave the hospital and relevant information passed to primary and/or community services.

(i) The discharge summary to the general practitioner should be written as soon as possible after the completion of the procedure/operation. Carbonless proformas are used in many hospitals to speed up the process. Dictating facilities are available in many theatre suites.

(ii) The discharge summary should be dispatched the same day by first class mail. In the future perhaps it will be faxed or conveyed by other electronic means. A duplicate should be given to the parents in case they require attention from the general practitioner before the mail arrives.

(iii) The discharge summary for the community nurses should be posted the same day and telephone calls made in cases where a nurse is required to visit within 24 hours. In many places this system seems difficult to manage efficiently and one audit showed that communication between hospital and community services failed to result in agreed home visits for a surprising proportion of cases. It was not clear at which point this failure in the system occurred. In some districts children who have had surgery are seen by the liaison district nurse before they leave the ward. Southampton has a parent-held letter (reproduced in Appendix II) which they are asked to show to the district nurse.

(iv) In the case of children with disabilities or chronic illness, specialists such as physiotherapists and occupational therapists, already involved with the child's care, should be informed of any special or additional needs arising from the admission.

28. Managerial and clinical audit should be a regular

part of the organisation and delivery of patient care. Monitoring should also include the views of parents and older children.

(i) The CCHS Committee feels that children should be identified separately from adults, since different issues are relevant.

(ii) Consideration should be given to carrying out clinical audit of day case admissions separately from inpatient care.

(iii) In addition to the routine collection of Korner data and clinical and managerial audit, the 12 quality standards (Part 2b) and the 42 principles (Part 2c) need to be regularly monitored. Statistics on rates of re-admission and rates of overnight stay are particularly important. Audit of the unit could be assisted by periodic assessment of the consumer view.

The following are some of the issues raised in the evidence:

- the appropriate timing of follow-up outpatient appointments so that all the results have been received
- operation notes secured in patients' notes at the time of the dressing clinic or review
- timely dispatch of general practitioners' letters
- proportion of home visits undertaken by community nurses in relation to those requested
- length of actual starvation compared with suggested length
- length of time between arrival and operation
- receipt of relevant information with the booking letter.

DELIVERY OF PATIENT CARE

This section covers issues that are closer to child and family during the episode of care, including some that draw attention to the need to exercise clinical judgement.

Outpatient and pre-admission period

29. The consultant should make the decision on whether to admit the child on a day basis, in co-operation with the family; if necessary the general practitioner and community staff should be involved.

(i) Once the consultant has decided, on the basis of the history and the physical examination, that the child is fit for day admission, a series of questions should be asked to check the social criteria listed in Part 4A. Outpatient staff from several hospitals have made the following suggestions of ways to ensure the information is gathered.

- It might be helpful to develop a check list, based on local social conditions.
- Research shows that consumers prefer to talk through these issues with nurses rather than doctors and the discussion can well be combined with the discussion of responsibilities (section 29(iv)), since in practice the two are linked and need the nurses' detailed knowledge of how the day is organised.
- In cases of doubt, a phone call to the general practitioner or health visitor usually clarifies the issue.

(ii) Any problems of transport to and from the hospital should be thoroughly investigated. The following should be considered:

- the effect of the rush hour on journey times in cities and also on the state of mind of the family
- the method of coming to hospital - public transport or private vehicle. When public transport is to be used, appointments should be timed realistically, allowing for the vagaries of the services
- when specialised tests are undertaken at tertiary centres, the distances might make day case admission unreasonable, unless free family accommodation is available
- two adults are necessary for the return journey, unless it is undertaken in a taxi or the family lives close enough to use a pram for infants and toddlers
- special situations, for instance a child in a hip spica.

(iii) Because they are likely to be anxious and outpatient appointments are so short, parents often forget what they have been told. It is helpful to them if the consultant checks that they understand the diagnosis and type of intervention proposed before a discussion of day admission is broached. In practice, with short consultation times, these two stages tend to get merged into one process. This can confuse parents.

(iv) Nursing staff should have sufficient time to talk to the parents to check that they have understood and taken in the consultant's explanation. In the case of operations, they should go through the parent's responsibility for starving the child, taking specimens and what to do if the child has a cold or other illness when called for admission. The problem caused by starving too long as well as the danger of eating and drinking should be covered. In the case of tests, the nurse should give an in-depth explanation of the planned procedure, as well as reassurance and support. Parents should be given an opportunity to express worries and accept their responsibilities. Special care should be taken with families whose first language is not English. It is also helpful to give parents a number

to telephone in case they think of later questions.

(v) A contact telephone number should be obtained. A telephone call can have three purposes: to check that the child is fit a short while before day of admission; to contact the family if operating time becomes available at short notice; and to make sure that the family understands their instructions and are well prepared. In some hospitals such a call has become routine (section 22(iii)). Others ask the parents to phone the night before to confirm that the child is fit and to check starvation instructions and time of arrival.

(vi) If possible the admission date should be booked at the time of the outpatient appointment and parents included in the decision. If there is a waiting list for day surgery, some idea should be given of the likely admission date.

30. The staff in the outpatient clinic and the day unit should jointly ensure that parents understand their role and responsibilities and are given verbal and written information to prepare for the admission, including care after discharge.

Preparation for parents is two-fold: to enable them to undertake their responsibilities competently; and also so that they can prepare their child (section 31). For parents it is essential that much of the information reaches them well in advance of the day.

(i) The following ideas were submitted in evidence to the CCHS Committee:

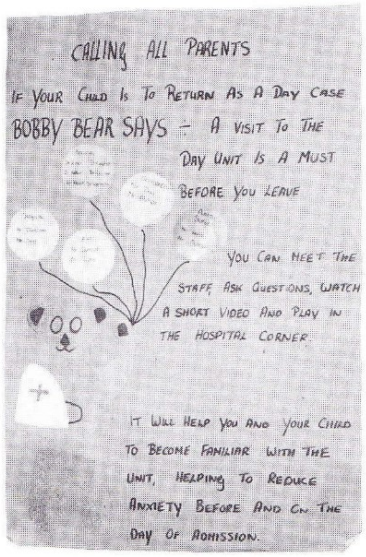
- Most hospitals send written information about the ward and hospital and what to expect. This can be confusing if it also covers inpatients. Ideally separate information should be prepared (section 25(i) has a list of suggested contents). It is also helpful to send separate information for the child.

- Work in the Netherlands suggests that preparation of the parent is more important than preparation of the child, especially since such a large proportion of children undergoing day surgery are under 5 years old.

- One study in the UK has shown that a special nurse in the outpatient clinic can be very effective. Her job is to go through the admission booklet with the parent, covering discharge issues as well as pre-procedure preparation (section 29(iv)).

- Many hospitals encourage an individual visit to the ward after the outpatient appointment. There is evidence that parents like this system and are not worried by the extra time involved. If it is more important to prepare the parent than the child, it can be valuable even if the outpatient appointment is far ahead of the admission date.

Poster inviting children and parents to visit the day ward, displayed in the outpatient department at Booth Hall Children's Hospital, North Manchester Health Authority, (Dept of Medical Illustration, Booth Hall Children's Hospital)



- One hospital in Canada has made a preparation video for day surgery and a local chain of neighbourhood stores has agreed to sponsor its use by holding copies for free borrowing. This works well and the high ownership of video machines may make it worth considering in the United Kingdom. To help families prepare themselves for a long-term illness that will involve many day admissions, videos can be especially helpful. "What happens next? Living through childhood cancer" has been designed for loan to families (distributed by Viewtech, Bristol).

- For families who are included in neither a ward visit nor a pre-admission programme, an album of photographs of admission/anaesthesia procedures, photographed on the actual ward, is a useful last minute alternative. A member of the play staff or the nurse allocated to the family for the day should sit down with the family and go through it stage by stage.

(ii) Arrangements for pre-admission preparation should be widely known in the outpatient department and reminder cards should be prominently displayed in the consulting rooms (Appendix II). Large posters in the outpatient department also attract parent's attention to the need for preparation.

31. A pre-admission programme should be provided for children as well as preparation on the day.

Most programmes involve parent and child together and some ideas are given in section 30.

(i) Some hospitals set up special pre-admission

programmes (videos, slides and hospital play) and invite the child and family. See Appendix II for a simple but informative invitation to such a session. These sessions are often for both inpatients and day cases and care is needed not to confuse by too much information geared to an inpatient stay. Some hospitals have found that parents are not willing to make an extra journey to hospital. The hospitals that achieve a high attendance rate combine the preparation visit with the pre-operative checks, but this means a second compulsory hospital visit which should not be necessary for day cases.

(ii) Play staff, ideally with a specialist training, should be available to help to prepare children in the pre-procedure period. Children attending for complicated diagnosis should not be forgotten.

On the day of admission

32. The management of day case children should reflect the fact that most are not acutely ill on arrival.

(i) On arrival, an atmosphere akin to a play group should be aimed for. Children should be allocated a locker rather than a bed (section 3(i)) and immediately encouraged to move to the play/recreation area. Most will not need to be put to bed at this stage.

(ii) If a block booking system is used, so that all patients on an operating/procedure list arrive at the same time, some children and their families will have a long wait and are likely to become irritable. This waiting time needs to be very carefully managed. Play staff are invaluable in organising play activities, not only to keep the children happily involved, but also to prepare them for procedures and reduce anxiety (sections 16 and 31).

(iii) Parents often complain about being asked the same questions twice. See Part 4b page18, for a parent's comment and section 24(vii) for a discussion of history taking.

(iv) If there is a delay in the operating list, care should be taken to ensure that young children are not starved for an excessive time. A recent study has shown that children are starved for much longer than the recommended minimum time, especially those on a morning list (Crawford 1989). See also Part 5b section 53(iii).

33. A parent should be enabled to be with the child and help with the care whenever the child is conscious and should be given timely, on-going information and support.

(i) Since there is a large amount of explanation and instruction needed for a successful day admission, it would be helpful for each family to be guided through the day by one nurse. Families attending for a series of tests or procedures can easily feel lost:

"There was a lot of nobody knowing anything and then we found we were expected in X-Ray at about 3.30....When we finally arrived I was greeted with 'So they sedated him for ultrasound and not for this? Poor little mite; this part's rather unpleasant.' You can guess I was far from reassured."

See also section 25(iii) for ideas on pre-procedure leaflets; and section 29(iv) for the role of nurses in the outpatient department.

(ii) For parents in the anaesthetic room see Part 5b section 57(i).

(iii) If parents are not allowed to have a drink or refreshments on the ward, the reason should be explained. One research study shows that 85% of parents fast alongside their children (Vessey et al 1990). The physiological consequences are likely to amplify psychological stress. Staff should discover whether the parent has had anything to eat and she should be encouraged to have a drink or a snack.

One parent described the situation on the ward post-operatively:

"Sister asked me to make Emma some toast because they were so busy. I had spent eight hours with neither caffeine nor tannin to keep me going, but I didn't quite dare make myself a cup of tea at the same time."

(iv) In the case of surgery, the time until the child returns to the ward, or the parent is asked into the recovery room, is a period of intense anxiety for parents. Reassurance should be given and if there appears to be some delay, the reason should be ascertained. In their evidence to the Committee, parents expressed this most forcibly.

"The first time Emma had an operation in this hospital, they told me that she would probably only be gone for half an hour. When three hours had elapsed I had come to the definite conclusion that something had gone appallingly wrong, that they had consulted the notes and seen that I had already lost a child and that they didn't want to tell me until my husband or parents had arrived. Of course, nothing had gone wrong; she had simply been kept in the recovery ward, but I was not to know that and I did suffer."

(v) Full information about the outcome of the operation/ procedure should be given to the parents by the nursing staff, registrar or senior house officer at the earliest opportunity.

(vi) The parent's voice can reassure a child and a parent should be asked if she would like to sit by the child in the recovery room, on the understanding that she might be asked to leave if there is an emergency in the room (Part 5b section 52(iii)).

(vii) If a child's discharge is delayed, the parent should be kept informed, so that she can make arrangements for home and if necessary to stay the night.

34. Every attempt should be made to eliminate, or reduce, the number of painful or frightening procedures and routines while the child is conscious and to keep the admission as pleasant as possible.

(i) The use of topical local anaesthetic cream is generally beneficial as an aid to painless venepuncture and its use should be encouraged.

(ii) Theatre gowns may cause anticipatory fear. Children should not be dressed in them until shortly before going to theatre and materials attractive to children should be used. Children should be allowed to keep on their own underpants.

Children at Sydenham Children's Hospital wear colourful operating gowns.
(Credit - Stephen Lovell-Davis)

(iii) There is a variety of ways of taking an alert child to theatre. Trolleys are usually unnecessary for day surgery and children should walk or be carried by a parent or nurse. Our evidence showed several unusual ways of getting to the theatre. In Sheffield Children's Hospital children can drive themselves in battery-driven vehicles and have the choice of a tractor or a Porsche! (see photo). In Nottingham and Preston trolleys are used, but they are disguised as Thomas the Tank Engine. A kit to transform trolleys is available from South Cleveland Hospital.

35. The anaesthetist should be responsible for the final check on the child's fitness for operation.

The anaesthetist should check that all the necessary information for the safe management of anaesthesia is available prior to the induction; this will include confirmation that the child is prepared, the parent informed and that appropriate drug doses can be calculated. Normally this is best achieved when the anaesthetist makes the pre-anaesthetic visit to the child on the day ward.

36. Anaesthetic and analgesic techniques appropriate to day patients should be used. Adequate post-operative pain relief should be ensured.

This section deals only with those aspects of anaesthesia that affect the delivery of care on the ward. For more details of paediatric anaesthesia once the child has left the ward, please see Part 5b. See also sections 34 and 35.

(i) It is common practice not to pre-medicate for day case surgery. However, on occasions premedication will be necessary and time for this to take effect should be allowed. Anaesthetists should be aware of many children's fear of intra-muscular injections and dislike of bitter oral medicine and prescribe accordingly.

(ii) Children should be encouraged to take their special toy or comforter with them into the theatre suite.

(iii) For post-operative analgesia see Part 5b section 59.

37. Nursing staff should take responsibility for mobilising the child and monitoring that he is ready for discharge.

(i) On return to the ward from a central recovery unit, children need to rest for a while, in their parent's arms or on trolleys/beds, until they feel ready to play or be more active.

(ii) Amongst the evidence received were nursing studies of post-operative care on the ward. One study found that nurses were erring on the cautious side in offering drinks and as a result were partly responsible for considerable discomfort, as well as the children having to be retained in hospital overnight. Children were offered their first drink at times that varied from 2 hrs

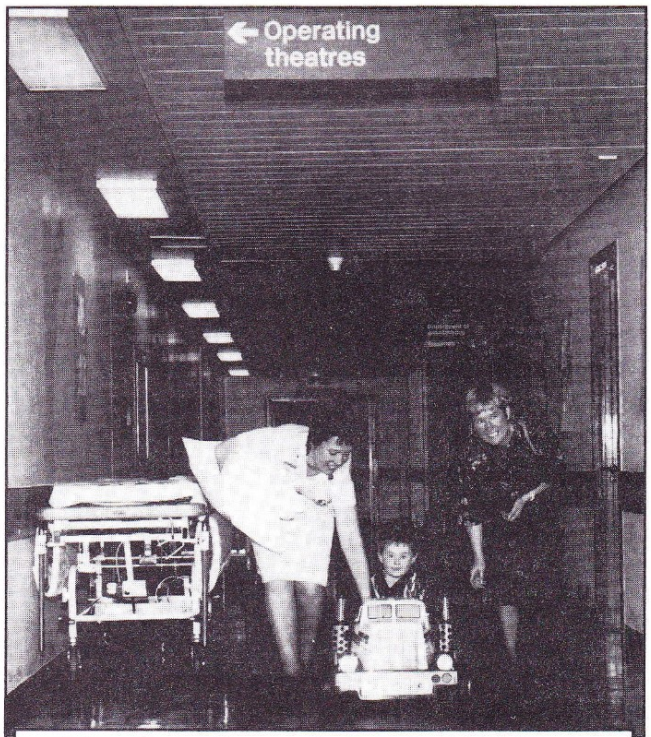
35 mins to 5 hrs 30 mins post-operatively (Crawford 1989). There seemed to be no policy on this and incidence of vomiting did not correlate with the lapse of time. In Southampton they find that most children can be discharged easily within four hours and many within two hours of surgery whereas in the study described above, most children had not even been offered a drink within that time.

(iii) If the decision on discharge is delegated to the primary nurse or sister, criteria for discharge should be agreed with the medical staff (section 39).

38. Nursing staff should ensure that parents understand the written instructions on post-operative care, are clear on what constitutes an emergency and know how to get help.

(i) It is the responsibility of the hospital to ensure that the patient has suitable transport home and, if necessary, to arrange hospital transport or a taxi.

(ii) Advice should be given on oral analgesia for home use. If necessary, sufficient medicine should be provided to provide pain relief until the parent can go to a chemist.



A day patient on his way to theatre at Sheffield Children's Hospital.
(Credit - Marcus Lastra, Royal Hallamshire Hospital.)

(iii) Each family should be given a post-operative advice sheet to advise the parent on follow-up care and return to normal activities (section 25 (v) for suggestions on content). Nursing staff should go through the sheet with the parent to check that its contents have been understood. Special care should be given to families from minority groups or others who might have problems with written English.

(iii) Each family should receive an instruction sheet advising parents on how and when to obtain help and advice (section 25(vi) for suggestions on content).

(iv) If a follow-up outpatient appointment is necessary, the date should be arranged with the family before discharge. If none is necessary, this should be made quite clear (section 25(iv)).

39. The anaesthetist should see all children during the recovery period, either in the central recovery area or day unit and should have agreed the criteria and delegation for discharge from the day unit to home.

(i) Protocols need to be established so that ward staff are aware of whether they expect the anaesthetist to come to the ward at the end of the list.

(ii) If the nurses or senior house officer have the delegated authority to discharge, protocols should be agreed. The following are suggestions from the evidence:

- observations are stable at a satisfactory level
- the child is up and playing without signs of dizziness
- the child is tolerating fluids
- the condition of the wound is satisfactory (where applicable)
- the child has passed urine (where applicable)
- the parents are happy about the child's post-operative condition.

40. The surgeon or a member of his team should see all children following day surgery before discharge from the day unit.

Nothing more to add.

Back at home

41. Parents should know where to seek medical help both for emergency and continuing health care.

See section 38(iii) for advice on follow-up care. In a situation where the family is advised to ring the hospital in case of emergency, the telephone numbers must be available when the day unit is closed, and patients' notes transferred to the ward which receives the emergency calls.

42. When the child has returned home, nursing care and/or advice should be provided for the family, as necessary.

Even confident parents can find the responsibility at home daunting:

"This is the point that upset me the most. If only someone could have come to tell me what I was doing was

correct and that it was healing properly. I have only praise for the staff at the hospital but felt that once we had left no-one really wanted to know. We felt very isolated and unhappy..."

Adequate support and advice should be provided after care has been transferred from hospital to home. This might vary according to the type of operation/ procedure carried out, but a visit by a nurse the following morning is advisable to give reassurance in the care of dressed wounds. Parents often value reassurance, too, following squint correction. For some long-term illnesses a community paediatric nurse is essential.

At the moment such support is provided by one of the following:

- a community paediatric nursing service, which offers this as one facet of their service
- district nurses
- health visitors