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**Day Surgery Australia**

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**July 2008**

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ADSNA wishes to acknowledge the talent and non-gratis work of Miss Megan Adams of Vizuri in the provision of the front cover graphics.

**Disclaimer**

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President’s message

Wendy Adams • President  Email: president@adsna.info

Welcome to our new Editor, Darren Johnston. He has been a very supportive committee member in Victoria and has attended a number of ADSNA meetings before accepting nomination for Victorian State representative at the national level. We are very pleased that he has agreed to fill the very big feet that Celia and Teena have left behind as well as very grateful that Teena and Celia have continued to support Darren and the committee from behind the scenes to ensure a smooth transition.

We are less than a year out from the International Day Surgery Conference to be held in Brisbane, July 2009. Unfortunately, a conference of this calibre is expensive and we have done all we can to keep the costs for nurses as low as is practically possible. Fortunately, ADSNA have a strong representation on the scientific committee and there is information in this journal regarding the call for abstracts. We would encourage all members to start seeking financial support from your work places and trade in order to be able to attend this very exciting conference.

During the year, many of the states have had very successful education sessions, seminars and conferences. I would encourage you to continue to support your state committee by renewing your membership, encouraging more members in your workplace, attending the various education sessions, nominating for your committees and writing articles!!

As an auditor for ISO 9001:2000, I have the privilege to visit many day surgery centres around Australia and am amazed at the variety of types of centres, challenges and experiences. It has been a vision of mine to share this with all our members and so this journal is dedicated to showcasing units from around the country. We have had many centres willing to showcase but time and space has limited us to the ones in this issue. However, we look forward to publishing the remainder in the next few journals. In addition, Ngaire Watson, a Barrister who so kindly provides our Legal Corner has researched and written a fabulous article Australian Nurses in the Perioperative Setting and Controlled Drugs: Are We Missing An Issue? However, limited space has meant that we have needed to hold the article over until our November issue. Once again, this journal is only possible because of a dedicated team behind the scenes who work tirelessly in their own time at the end of a busy day in their own day surgery units. So, sit back, pour your favourite drink and enjoy reading!

Editor’s desk

Darren Johnston • Editor Day Surgery Australia

It is with great pleasure that I introduce myself as the new Editor of this exciting and informative journal. I am a division 2 (enrolled) nurse and have worked at the Peter MacCallum Day Surgery Unit for over 5 years. Originally I came upon day surgery almost by chance as a regular favourite job during a 2 year stint as an agency nurse. Since that time I have found that my specialty lies in day surgery.

I only hope that I can keep up the great standard of my predecessors – Teena Brush and Celia Leary. I would like to thank Teena, Celia, Wendy Adams and Helen Taylor for the great support they have given me in the putting together of this fabulous journal. I would also like to thank our many contributors and reviewers, whose input makes this journal possible.

For this journal we have put together a special edition that focuses on showcasing a selection of day surgery units from around Australia and abroad. Each and every unit is unique in what we do, how we do it and the special set of circumstances that brings it all together. I know I can speak for myself and many day surgery nurses that I know in saying that it is always great to get to have a bit of a sticky beak into other day surgery units. From this we can always take away some ‘food for thought’ about how we do things in our own units and what we can learn from others.

Also in this edition you may find the legal corner very interesting. The practice of distributing drugs throughout a theatre list can be controversial. We are all put under pressure to work as efficiently as possible and yet the law can be confusing when it comes to some of our practices, especially when it varies from State to State. Therefore some definition is always welcome.

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Showcasing the day surgery unit

Adelaide Eye & Laser Centre, SA

Dorothy Skinner • Business Manager

In 1999, Dr Peter Ingham, an Adelaide ophthalmologist, developed a free standing consulting and day hospital facility known as the Adelaide Eye & Laser Centre (AE&LC). It followed several years of practice at rooms associated with the Ashford Hospital where Dr Ingham performed cataract surgery, whilst refractive surgery was undertaken in house at his consulting rooms. The Centre is adjacent to the southern parklands, which abut the CBD, and is convenient for north, south, east and west access. Undercover parking and lift access is available, which is particularly important for the more elderly patients.

Dr Ingham’s vision was to develop a purpose built facility offering excellence in care, technology and environment. The design and construction took several months, with Dr Ingham, as Medical Director, being closely involved throughout the development. Finally opening in June 1999, AE&LC, successfully gained accreditation with ACHS in November of the same year and has since maintained this status. Further development and refurbishment took place in 2006, at which time the consulting rooms, administration offices and waiting room facilities were redesigned and increased, thereby offering improved facilities for surgeons, staff and patients. In April 2008 ISO 9001:2000 (incorporating the Private Sector Quality Criteria) Global-Mark® certification was successfully achieved and AE&LC looks forward to continuing with this programme and maintaining its focus of excellence in care. AE&LC is the only fully licensed and accredited Excimer laser facility in South Australia, and is proud to have taken on this initiative.

Mission statement

AE&LC aims to provide premier personalised care for patients with visual problems in order for them to gain better health, wellbeing and an improvement in their overall lifestyle. We will achieve this outcome by providing outstanding service through clinical care, innovative surgical techniques, experience and customer focus.

The Centre’s priority is to the level of care given to the patient at all times and, as such, the above statement supports our ideals. The statement is included in brochures and external mailouts, various internal documents and is primary in the minds of all employed.

The unit

The day surgery area comprises a cataract theatre, a refractive theatre and a procedure room, together with a three bed recovery and a four person recliner chair recovery area. There are two interview rooms for preoperative and postoperative assessments, together with change facilities for medical staff, dirty and sterile utility rooms, store room and restrooms for both patients and staff. A waiting lounge is provided for tea and coffee making, the latest magazines, a courtesy phone, television and a children’s play area. Seating includes Macrohide™ chairs and two seater lounges, offering relaxed, comfortable and professional surroundings for patients, carers and family.

The patient mix includes those for cataract and refractive surgery and selected general ophthalmic cases. All patients are assessed during a pre-assessment consultation with the technical staff, optometrist and the surgeon. At this time, the patient’s suitability for surgery
is determined and, if surgery is to proceed, they then liaise with the registered nurse for the booking of a mutually agreeable time for the procedure.

On the day of surgery, the patient is admitted by the receptionist to the AE&LC Day Hospital. The nursing staff then admit the patient to the operating suite and performs preoperative observations. The patient has a consultation with the anaesthetist in the recovery area prior to the commencement of surgery. Preparation of the patient includes the instillation of eye drops and IV sedation given by the anaesthetist. Postoperatively, the patient is transferred to recovery for observation. When observations are satisfactory, usually after 10-15 minutes, the patient is then assisted to a recliner chair prior to being assessed for discharge. The Chung et al. Post-anaesthesia Discharge Scoring system (PADS) is completed and, if the criteria are met, the patient is discharged from AE&LC to the carer or relative. The patients are given drops, and written and verbal postoperative instructions including after hours contact details. All patients are seen by the surgeon the following day and again 1 week after surgery.

AE&LC employs three full-time registered nurses, one being a nurse manager who assumes responsibility for the day to day running of the day surgery. Casual and agency nurses assist with the additional tasks on theatre days.

Consulting rooms provide the latest technology such as 2020 Vision Systems, providing complete Visual Acuity Systems and making testing and analysis for ophthalmologists, optometrists and technicians easier and faster. The Wavefront Analyzer is used to tailor corneal treatments for refractive patients by mapping ‘aberrations’ of the eye, and the Allegro Oculyzer and Oculink software performs the mapping of the cornea which enables advanced topography-guided treatments. These treatments have been optimised to complement the range of customised laser vision corrections and to interact in perfect synchronisation with the Wavelight Excimer laser systems. Optometrists, orthoptists and technicians are employed to assist the surgeons with the technical aspect of the consultation. The facility is run by a business manager, supported by the administration manager and Quality Improvement Committee (QIC).

Considerable emphasis is placed on improving performance and the QIC plays an active role in achieving the accredited status. The medical director also actively supports improvement activities and encourages development in IT systems, patient literature, staff training, and the general environment of the workplace.

Our achievements

With our focus on the latest technology in the ophthalmic and the business administration aspect, AE&LC is continually striving to achieve higher standards by adopting a continual improvement policy. New IT hardware and software have been implemented over the last 12 months, offering better access for off-site use. This enables staff to be more flexible with in-office work hours and improves overall productivity. The new hardware also addresses the issues of redundancy and minimises potential risks. Having recently gained ISO 9001:2000 certification, our systems to mitigate potential risks have greatly improved and, from a business perspective, we believe this compliance is most beneficial.

We are considering an upgrade to the microscope for the cataract theatre and are presently trialling the Zeiss microscope. Also being assessed are new Phaco handpieces and, recently, a new pre-loaded Carl Zeiss Intra Ocular Lens was introduced which has brought greater efficiencies to the procedure with good results for the patient.

Accounting systems are to be improved with the introduction of MYOB. This will bring us in line with our external accountants and will make the transfer of information more efficient, giving us greater reporting opportunities.

In conclusion, AE&LC and its team will continue to push the boundaries in pursuing its quest for excellence in healthcare and patient outcomes by providing the latest in techniques, equipment and environment.
Showcasing the day surgery unit

The Angliss Day Procedure Hospital, VIC

Beverley Sullivan • Clinical Nurse Specialist

The Angliss Hospital is an Australian public hospital located in upper Ferntree Gully at the foot of the Dandenong Ranges in the eastern suburbs of Melbourne, Victoria. It is a member of Eastern Health, a metropolitan public health service that has been fully accredited with the ACHS since 1984. The hospital has recently undergone extensive redevelopment and now boasts a state of the art emergency department, coronary care unit, high dependency unit and a 30 bed rehabilitation unit with a total of 173 acute beds.

Day surgery commenced at The Angliss Hospital in 1996 in a six bed area on a medical/surgical ward. It was relocated in March 1998 and again in May 1998, finally moving to its present location in the old emergency department in July 2006. It is now known as The Angliss Hospital Day Procedure Unit (DPU). Refurbished and remodelled, it can now accommodate the increased demand for day procedures and includes patients coming from all areas of Melbourne.

The DPU is attached to the operating theatre (OT) and comes under perioperative services. Entry into the OT is via the holding bay area. All surgical patients, except some obstetric patients, are admitted through the DPU, with the long stay patients being transferred to the wards direct from first stage recovery. The DPU consists of the admissions area with two admission rooms, three toilets and shower facilities. The preoperative and second stage recovery has ten trolley bays and a nurses’ station. The lounge area has ten recliner chairs, which are utilised for endoscopy lists, third stage recovery and patients awaiting discharge. A transit lounge with nurses’ station is incorporated into the DPU in a designated area.

Staffing consists of a nurse unit manager (NUM), two associate nurse unit managers (ANUM) who job share, four clinical nurse specialists (CNS) and five division I nurses who work on a permanent part-time basis, one graduate nurse who works full-time and two division 2 (enrolled) nurses who work permanent part-time. The unit also has ward support staff and clerical staff.

There are three operating theatres catering for morning and afternoon lists and also emergencies. The procedures frequently performed through the DPU include women’s health, ear, nose and throat surgery, endoscopy, vascular surgery, general surgery, paediatrics and urology. The DPU cared for 4422 patients (both adult and paediatric) over the last year, of which 3485 were short stay patients, 863 long stay patients and 74 medical patients for procedures such as blood and iron transfusions, lung biopsies and ascitic drains. A waiting list exists for general, ENT, gynaecology, vascular, endoscopy and paediatric surgery. Patients are prioritised by 1-3 categories and admission arranged according to priority. Extra lists are often scheduled if resources are available.

Our unit

The surgeon recommends those patients who require assessment for co-morbidities, pathology or radiology to the pre-assessment clinic which is run by nurses, with an anaesthetic registrar on call to review patients as required. Morning list patients fast from midnight and, depending on the anaesthetist, may or may not have 150mls of water at 0600hrs on the morning of surgery. Afternoon list patients have a light breakfast to be finished by 0730hrs and, depending on the anaesthetist, may or may not have 150mls of water at 1100hrs. Endoscopy patients follow special diet instructions as per their consultant.

Admission times are staggered from 0700hrs for a morning list and 1100hrs for the afternoon list. Staggering the admission time creates a smoother flow and reduces length of wait for surgery. Congestion of the waiting area is minimal and patient comfort is assured.

Following admission by the clerical staff, the nurse completes the admission process by checking all the paperwork, ensuring an informed consent (the patient understands the surgery to be performed), verifying medications that may have been taken, and ensuring that vital signs are documented and that pathology results are available. Referrals required for discharge (e.g. hospital in the home, post-acute care services, health psychology) are completed. Permission is obtained for follow up phone calls and relevant telephone information is documented on a form containing patient details, type and date of surgery, consultant’s name and questions that will be asked during the follow up call. The patient then is changed into a theatre gown and taken to the lounge or taken to a trolley bay to change. The anaesthetist will see the patient either in the DPU or the holding bay in the OT.
Day patients’ belongings are either put into a basket and locked in a cupboard in the lounge area, or, for patients being admitted to a trolley, they can store valuables and personal items in a lockable drawer in the bedside locker alongside their trolley. Keys to both the bedside lockers and the locked cupboard are on the nurses’ keys. Longstay patients’ belongings are kept with them until they go to theatre and then are taken to the wards by a nursing attendant.

Nursing staff in the DPU do not rotate through the OT or first stage recovery, caring only for patients preoperatively and postoperatively. They are responsible for escorting the patient to the holding bay, providing a handover with the holding bay nurse, collecting patients from first stage recovery when the recovery room discharge criteria is met and escorting them back to the DPU for further recovery and discharge. Patients’ progress is monitored and documented throughout their stay.

When appropriate, the carer is contacted and informed of the estimated discharge time. Diet and fluids are provided and prescriptions may be filled by the pharmacy department. A check is made to ensure all referrals are completed and organised. When the discharge criteria is met (nine out of ten of the Chung Score), all discharge information is discussed with the patient and carer before leaving. Patients unable to be discharged home and requiring an overnight stay can be transferred to a ward bed organised via the coordinator on duty.

All short stay patients receive a follow up call on the day following discharge, with the exception of endoscopy patients and those referred for follow up with Hospital in the Home Services. Staff will attempt to make contact with the patient twice only.

**Our achievements**

**Paediatric patients**

Each child admitted receives a show bag containing pens, pencils and colouring and puzzle books to occupy them during their wait for surgery. A play area is provided in the lounge with toys donated by a grateful family. A Starlight Foundation activity centre is available for use with computer games, DVDs, movies and PlayStation games. On occasions, Captain Starlight and his team have visited our unit to entertain the children.

A DVD was also made for children coming into the unit called Can Jaffa come too? originating from the name of the teddy bear that ‘the star’ Matthew had with him. This has been an excellent tool used to allay the child’s fear of the unknown. On discharge, each child is given a Jaffa Bravery Award which can be decorated with stickers. The award is proudly sponsored by the Ferntree Gully Auxiliary Group who also make the show bags.

**Women’s health**

We believe we also do an outstanding job in supporting day procedure patients through a miscarriage. Apart from normal admission procedures, it is necessary to determine blood group; if the patient is a negative blood group she will require Anti D. Antenatal classes and the midwifery booking must be also cancelled. Referrals are completed for health psychology, SIDS (sudden infant death syndrome) and miscarriage information for parents and their families is made available. We like to offer a small keepsake of booties and bonnet in an organza bag with a remembrance card of the baby. It is essential to these patients to provide privacy and to offer comfort at what can be a very emotional time. Anti D, if required, is given in recovery and normal postoperative procedures are followed before discharge. We are very proud to boast about the care we provide for these special patients.

The staff at The Angliss DPU work in a very supportive atmosphere, generated by our very positive nurse unit manager who leads by example and successfully cultivates a positive work place. This filters through to all the staff that work in the unit, creating excellent team work. Patients and their families have commented on how well we work together and seem to enjoy our work. We celebrate birthdays, socialise together on occasions and a most anticipated event each year is our weekend away when we just relax and enjoy each other’s company.

**Our aim**

Our aim is to continue to provide the excellent quality of care that we do now. Through education and review, we will keep our skills up to date and incorporate new advances in day surgery into the care we provide on a daily basis.
Showcasing the day surgery unit
Ballarat Day Procedure Centre, VIC

Felicity Connor • Nurse Unit Manager

Ballarat Day Procedure Centre (BDPC) is a private facility in Victoria’s largest inland city. Ballarat is a rural city boasting a population of nearly 90,000 residents and is situated 75 minutes drive west of Melbourne. BDPC was the first stand alone unit to be built in Victoria and was officially opened on 6 March 2002. It is located close to the centre of the city and services 21.4% of the State. The facility combines state of the art equipment and the best medical technology available. The design aesthetics of the Centre provide a non-clinical and non-threatening environment for patients.

The organisation currently employs 39 staff, including nurses, anaesthetic technicians, reception staff, CSSD and cleaning staff. Attached to BDPC is also an IVF laboratory, a haematology service and day oncology, which was opened in March 2004. The philosophy of the BDPC is to provide patients with the highest level of care, effective treatment and sound management. The fundamental philosophy of the Centre is grounded in the belief that each individual is worthy of respect.

The Centre implements a Quality Management System in accordance with International Quality Standard AS/NZS ISO 9001:2000 as well as the Private Sector Quality Criteria which ensures that only the highest standard of patient care is given by our staff to meet the needs and expectations of our patients and referring practitioners. Our management system incorporates both environmental management and occupational health and safety procedures that comply with all the current statutory regulations. It is the prime objective of the Centre to provide quality healthcare in a safe, skilled, caring and supportive environment, which safeguards the privacy and rights of our patients and their families. A commitment by the Centre to continuous quality ensures that the prime objectives are delivered at the highest possible level. BDPC is accredited through Global Mark.

The facility has a Board of Directors who make up the Medical Advisory Committee (MAC) which meets at least twice yearly. The MAC meets to ensure that the Centre complies with all requirements of the relevant legislation. The Committee makes recommendations to the Management Review Committee (MRC) regarding clinical practice, ethical and professional conduct and coordinates the activities of all practitioners. The MRC consists of the CEO, DON, who is also the quality manager, the quality coordinator, the administration manager and the associate charge nurse of the day procedure and oncology unit. The MRC is responsible for ensuring that our quality system continues to be effective in satisfying the requirements of all the relevant standards, codes, legislation and the requirements of the facility.

BDPC runs three theatres, 13 beds used on a rotation system, eight routinely used recovery bays (13 in total) and 13 recovery recliner chairs in second stage. The Centre caters for a variety of specialties, including orthopaedics, general, gynaecology, ophthalmology, ENT, plastic surgery, reconstructive surgery, IVF, oral and dental surgery and endoscopy. The day oncology suite is a 12 chair, three bed facility treating day patients requiring medical or oncology treatment. There are three treating oncologist rooms attached and visiting physicians also treat patients. Oncology services include administering chemotherapy, blood products, other drug treatments and maintenance of central venous devices. Oncology nursing staff provide patients with information, education and ongoing support throughout and after treatment. BDPC is also involved in teaching and takes on several nursing students each year from various universities, thus continuing to produce quality perioperative nurses for the future.

One of the greatest achievements of the BDPC is definitely the growth of the Centre since opening in 2002. In the first year 1,200 patients were admitted; 6 years later, the Centre caters for approximately 8,000 patients per year. A busy day can see up to 45 patients admitted for surgery and 20 patients for oncology services. The emphasis on increasing patient numbers was achieved through widening our user base. In 2002, 12 specialists used the facility and we now have over 23 specialists and a number of dentists regularly working with us.

Open access endoscopy is also a service we provide whereby patients are sent to the Centre directly from their local general
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practitioner (GP) and are added to the next available endoscopy list. The patient sees the endoscopist on the day of surgery and, if there are no major problems found during the endoscopy, the patient is referred back to their own GP for follow up. If any major problems are found, follow up is undertaken by the endoscopist involved. This process has a two fold effect; first by reducing the time patients need to wait to see a specialist and, secondly, filling otherwise small endoscopy lists.

Our Centre is very proud of the achievements of the IVF laboratory. The IVF laboratory is connected to unit and we are directly involved in the care of IVF patients during procedures such as ovum pick ups (OPUs), sperm aspirations (PESAs) and testicular biopsies and, on occasion, embryo transfers which are conducted under sedation. Our IVF programme has continually had success rates above the State and national average for pregnancies.

BDPC caters for both adult and paediatric patients over 12 months. A rigid appointment process eliminates patients waiting for long periods. Admissions are staggered throughout the day, sometimes with patients being admitted 15 minutes apart depending on the type of surgery being performed on each list. Patients phone for their admission time, information on taking medications, fasting times, expected discharge time and any other information relating to their upcoming procedure on the day prior to surgery as this is when lists are finalised.

All pre-assessment interviews are conducted by the admitting doctor and, if necessary, patients may be referred to the anaesthetist involved for consultation prior to admission. Patients complete their own medical history form which is reviewed by the nurse on admission. Patients are first entered onto the computer system at reception before being taken to the change rooms by the admission nurse. This nurse is responsible for checking all patient details and patient consent before preparing them for their surgery/procedure. The patient is then placed on a bed in the ‘holding bay’ and personal items placed in a bag underneath the bed (patients are encouraged to bring their own re-usable bag to reduce plastic bag use and waste). The surgeon and anaesthetist both see the patient in the holding bay preoperatively.

Surgery is undertaken in one of the three theatres of the Centre and then the patient is transferred to the recovery area. All surgical instruments are processed on the premises by CSSD technicians, and endoscopes are processed by specially trained nursing staff.

Patients are required to remain at the Centre for a minimum of 1 hour following administration of any sedative drugs. The time spent in the first stage recovery depends on the type of anaesthetic administered, the type of surgery and the conscious state of the patient. Patients are discharged to second stage recovery when they are fully awake and orientated, observations are stable, pain and nausea is under control and there is no evidence of bleeding. A discharge score out of 25 is recorded and a minimum score of 15 is required before discharge to second stage recovery. This is a scoring system that has been developed over the years by the medical and nursing staff which includes physical appearance, nausea/vomiting, pain, ability to ambulate unaided as per pre-admission and bleeding. Any patient who is not well enough to be discharged can be transferred to one of the two major local hospitals for further treatment, an event that does not happen very often.

Patients are dressed in the recovery area behind screens for privacy, and then either walked with the support of the recovery nurse or pushed in the wheelchair through to the ‘dayroom’. A choice of food and fluids (usually sandwiches, biscuits and the choice of hot or cold beverages) is available and dietary requirements are taken into consideration. Follow up appointments are made by the nurse and the carer is contacted. Discharge takes place when the minimum time of 1 hour has elapsed and all discharge criteria met. Verbal and written discharge instructions are provided to the patient and carer. This information consists of a generic instruction page, with emergency telephone numbers (a mobile number manned by the director of nursing), and general post-anaesthetic instructions. Procedure specific instructions may also be provided, as well as a prescription, if required and a medical certificate, if necessary. Patients undergoing arthroscopy are given an intraoperative visual record of their procedure (Digital Image Capture System video).

Follow up phone calls are conducted on all patients the day following discharge. The patient is asked how they are feeling, pain status, wound status, nausea and if they have any other problems. Where unexpected or worrying symptoms are noted, the patient is advised to contact the surgeon or the anaesthetist, or can be directed to present to the emergency department of their local hospital. Random patient satisfaction surveys are given out throughout the year and the data is collated in an effort to continually monitor and improve our service.

The BDPC has become a very successful business and an excellent centre for patient care. Patient feedback continues to be very positive, indicating the dedication of all staff toward the care of every patient. BDPC looks set to continue operating and growing into an extremely busy, well run, stand alone day procedure unit into the future.
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Timothy E. Kremchek, M.D.
Orthopaedic Surgeon
Sports Medicine Specialist
Beacon Orthopaedics and Sports Medicine
Cincinnati Reds Medical Director
Cincinnati, USA
Showcasing the day surgery unit

Darwin Day Surgery, NT

Mr Ravi Mahajani

Darwin Day Surgery is located on the first floor in Fannie Bay shopping precinct, a suburb of Darwin in the Northern Territory. Due to the increasing demand for plastic and reconstructive surgery, a dedicated freestanding day surgery was needed. This was to be the first stand alone day surgery unit in the Northern Territory for patients requiring sedation anaesthesia. The unit is the brainchild of two very motivated nurses, Maureen Schaeffer and Joanne Kovac, founders of Darwin’s foremost nursing agency (Golden Glow Nursing) and Mr Ravi Mahajani, Darwin’s only resident plastic and reconstructive surgeon and Director of Northern Plastic Surgery NT.

The Darwin Day Surgery group acquired the rooms in Fannie Bay that had previously housed a dermatology and psychiatry practice. One half was sectioned for Northern Plastic Surgery and the other dedicated for Darwin Day Surgery. The cohabitation of the two entities has proved to be convenient for both patients and staff.

Darwin Day Surgery implemented a Quality Management System in accordance with International Quality Standard AS/NZS ISO 9001:2000 as well as the Private Sector Quality Criteria. They were successful in receiving certification in November 2007, which then enabled them to be licensed with the Commonwealth as a day hospital. This is an interesting scenario as, because the Northern Territory government is not a State government and cannot issue hospital licences, a commonwealth licence was required. With accreditation and provider number in hand, Darwin Day Surgery was able to successfully negotiate contracts with the health funds. In the Northern Territory, only one other private hospital exists – Darwin Day Surgery was able to provide an alternative choice for patients requiring plastic and reconstructive surgery without having to travel interstate. Currently, cases are confined to those patients suitable for sedation anaesthesia.

At present, Mr Mahajani is the only surgeon – the plastic and surgical repertoire includes mainly skin lesion pathology, hand surgery and some aesthetic surgery, namely blepharoplasties. Four anaesthetists are credentialled to work at the unit, with two of the four being members of the Medical Advisory Committee. Other staff include an administrative officer and, on operating days, three to four registered nurses are present to manage the operating theatre (OT) and recovery. There are two principle nurses who oversee the day to day running of the OT. The facility is accredited with the NT clinical school and the Charles Darwin University, which enables medical and nursing students to participate in the surgical procedures.

The unit consists of a reception, a preoperative holding area, OT and second stage recovery. The layout is such that only one person is in the preoperative holding area and a maximum of two in second stage recovery at any one time (although four can be accommodated), which allows privacy and intimacy for the patients. First stage recovery is performed in the OT and the anaesthetist determines when the patient is ready to be transferred to second stage recovery. Careful selection of patients is essential as the unit is located on the first floor and there are no lifts. The patient is required to be able to walk up the stairs prior to the procedure and down the stairs upon discharge. There are provisions for emergency transfers but this location has meant that some patients have been deemed not appropriate for the unit.

An unusual challenge for Darwin Day Surgery, unique to the tropical areas of Australia, is cyclones. A cyclone watch is issued when gale force winds are expected within 48 hours. Although it is business as usual at this stage, alerts are repeated every 6 hours and all staff monitor these reports carefully. The cyclone warning is issued when gale force winds are expected to hit within 24 hours and all staff have very specific emergency guidelines to follow which includes cancelling all surgery until further notice, disconnecting all equipment from power which is then taken into the OT (the cyclone shelter), taping windows from corner to corner, turning off power at the switchboard and locking up before leaving to organise their own homes and families.

To date, Darwin Day Surgery has performed over 300 cases. The OT operates 1.5-2 full days per week. Emergency work can be performed after hours or on weekends. The group hopes to diversify within the plastic surgery field and also into other surgical disciplines. To assist the plastic surgeon, moves are afoot into the purchase of a microscope and enquiries are being made in regards to an image intensifier for orthopaedic hand surgery. The group has not canvassed interest from other clinicians at this time but hopes to in the future. In the current location, the set up is not appropriate for general anaesthesia; however, when the day surgery moves into its own purpose built facility, the group will evaluate day surgery general anaesthesia and perhaps extended stay procedures. Acquiring land in the Northern Territory is a challenge with the many restrictions on land rights, meanwhile, careful planning and appropriate patient selection is the key!
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Showcasing the day surgery unit

Melbourne Oral & Facial Surgery Day Hospital, VIC

Brett Grant • Executive Director, Bachelor of Business RMIT (with distinction)

Melbourne Oral & Facial Surgery Day Unit (MO&FS) is a unique facility, as it is the only day hospital in Melbourne that has been purpose built and designed to provide general anaesthesia for oral and maxillofacial surgery procedures. It is located in the heart of the Melbourne CBD at Level 12, 63 Exhibition St. The unit is highly accessible by public transport or car and has discounted public parking arrangements within 200 metres of the facility.

Since our inception in January 2006, the hospital has more than doubled the annual number of patients cared for and it is anticipated that this growth will continue into the next financial year. This is a direct result of the level of care our patients receive and the fact that our surgeons are highly respected leaders in the oral and maxillofacial field.

The Centre implements a Quality Management System in accordance with International Quality Standard AS/NZS ISO 9001:2000 as well as the Private Sector Quality Criteria. The facility has one operating theatre, five recovery beds and four consulting rooms that have been designed to assist the staff in providing a high level of care to patients. The centre is staffed by permanent part-time and casual nursing staff, who are supported by the director of nursing (DON) and the Medical Advisory Committee (MAC).

As a stand alone facility, the Centre has a patient transfer arrangement with both St Vincent’s and Epworth Hospitals. The facility only admits ASA 1 or 2 patients and there are strict guidelines for paediatric patients who must be at least 8 years of age and weigh 30kg before being admitted. MO&FS averages 1600 cases per year, which includes wisdom teeth extraction, implants and minor jaw surgery under either IV sedation or general anaesthetic.

Preoperative assessment

All patients are given their admission paperwork and information regarding the cost and proposed procedure at the initial consultation with the surgeon. They are asked to complete the medical history and personal detail sections and return them to the surgery prior to their scheduled procedure date. A week to 3 days prior to the procedure date, the surgeons’ personal assistant will conduct a telephone interview with the patient. During this interview current medication is discussed, along with any major health issues they may have. If any issues are noted during this interview, the DON and/or surgeon will be notified for further follow up.

Day of surgery

On the day of admission, the surgeons’ personal assistant greets each patient on arrival. The financial process is completed, the anaesthetist interviews the patient and a preoperative examination is performed. The admitting RN will then interview the patient and ensure that they understand the procedure to be performed and records base line observations. Lots of reassurance and TLC is given at this time.

A premedication of Nurofen is given to the majority of our patients. All our patients are given local anaesthetic infiltration (LA) along with a general anaesthetic (GA). Most patients receiving the premedication awaken pain free. LA infiltration can last up to 12 hours postoperatively, providing good pain relief. Warming blankets are used for each patient during their procedure and this is retained throughout. We have found that by maintaining the patients’ temperature perioperatively, our patients have less pain and a faster
recovery period. Patients are transferred from first stage to second stage using the Aldrete discharge scoring system.

**Discharge and follow up**

Patients are discharged using the Modified Post Anaesthetic Discharge System (PADS). Written postoperative instructions are given which include information on: general anaesthetic effects; pain, nausea and vomiting management; postoperative bleeding management; post-procedural care details; legal limitations for 24 hours following a general anaesthetic; and after hours emergency contact details.

Patients receive a follow up call 24-48 hours following discharge to check on their progress. This ensures patients are recovering as expected and allows collection of information on patient satisfaction to ensure that we have met their expectations. This provides excellent feedback, which is then reviewed by our Medical Advisory Committee and management team. We continually aim to fine tune our processes.

**The future**

The future plan for the facility is simple – maintain a work environment that prides itself on providing superior care to our patients. This will be achieved by ongoing certification with ISO 9001:2000, ongoing education for the nursing staff, with quarterly internal training days, and encouraging professional development via external courses and conferences. These will ensure we keep abreast of current trends and developments.
Showcasing the day surgery unit
National Day Surgery, Sydney NSW

Nancy Broer • RN MRCNA, Director of Nursing

Introduction
National Day Surgery, Sydney is a purpose built, private, freestanding facility that opened in May 2006, offering skilled specialist services in an advanced technological setting. Situated in Derby Street, Kogarah, it services the surrounding area but also has patients coming from the north shore of Sydney, NSW country areas and Tasmania. National Day Surgery received 4 years’ ACHS accreditation in August 2006. The comfort and wellbeing of our patients is paramount and we aim to provide comfortable and attractive surroundings where they are looked after by skilled medical, nursing and administrative staff.

Structure and staffing
Our unit has three theatres with integrated IT facilities, 12 recovery beds and 13 patient lounges in the discharge area. The unit is staffed by the DON, one full-time NUM in recovery, eight part-time nursing staff (RN and EN), who may work full-time hours as required, and 21 casual staff (RNs and ENs), including CSD staff. We have one staff member who looks after infection control issues and one staff member who attends to OH&S and manual handling issues. Mandatory training is conducted each year by external consultants and 2 days are allocated to ensure that all staff members can attend. In addition, all staff are encouraged to undertake personal development education and training in all areas of day surgery. We encourage our staff to become members of the appropriate professional associations in order that they remain up to date on new trends and developments.

Activity
Since opening, our activity rates have gradually increased as more specialists have come on board and we now perform around 500 procedures per month. Our main specialties are orthopaedics, ophthalmology, urology and some dental procedures. Our age range is 6 months – 90+. Recently we have acquired a plastic surgeon who has commenced hand surgery and we hope to expand to more plastic surgery in the future.

Journey of care
Our surgeons manage their own operating lists and the request for admission (RFA) and consent is completed by the surgeon in his rooms and given to the patient to complete their medical history. The surgeon will also attend to any pathology or tests that he wishes performed at this time. The patient may then post or deliver the RFA in person to the unit. Written instructions regarding admission times and procedures, fasting and what to do on day of admission are included in the RFA. If the RFA is hand delivered personally by the patient, the RN will complete a preoperative assessment at that time. If the RFA is posted, the RN will check the medical questionnaire and may phone the patient if clarification or further information is required. This gives the patient the opportunity to ask questions. Patients are requested to phone the unit the afternoon before surgery for their admission time. Patients are requested not to bring any valuables; if they do, they are locked in the safe. Lockers are provided for patients’ clothes.

Admission times for some lists are staggered, whilst others are not, depending upon the instructions/preferences of the surgeon or anaesthetist. Occasionally we will be asked to perform an ECG on admission. The anaesthetist will see his patients preoperatively on the day of admission. Our urologists have their own nurse who attends to the preoperative requirements and also follows up with the patient postoperatively. Fasting regimes are according to the anaesthetists’ request and vary accordingly.

Following surgery, patients are accompanied to recovery where they are closely monitored and observations recorded every 10 minutes for 30 minutes or until stable, with no or minimal pain or
postoperative nausea and vomiting. Average stay for most patients is 2 hours. Those having cataract surgery normally have one set of observations before moving to second stage for tea and sandwiches and are mostly discharged 30 minutes postoperatively. Patients having shoulder surgery stay 4 hours, as they require IV antibiotics, and anterior cruciate ligament repairs (ACLs) stay 3 hours. No drains or pain pumps are used as the anaesthetists have specific written plans for pain control. Ice packs are used for shoulder surgery, ACLs and some ocular plastic patients.

We use Chung’s Modified Post-anaesthetic Discharge Scoring System (PADSS) and clinical pathways to assess patients’ ‘readiness for discharge’. Written postoperative instructions, which may be either general or procedure specific, are given and all instructions are verbally explained to both the patient and carer. The carer signs a patient compliance statement on discharge, confirming that postoperative instructions have been received and understood. Patients who are unable to make satisfactory arrangements for a carer postoperatively or who have more extensive procedures and require extended recovery, i.e. shoulder replacement, may be transferred to the local private hospital with which we have an agreement.

Follow up phone calls are made by the RN to assess how the patient is managing, usually the following day or within 48 hours. Surgeons are aware that the unit requires feedback should any patient have signs of a postoperative infection. To date, only two have been reported.

Greatest achievement

Our greatest achievement would be the success of our shoulder replacement surgery. We have performed 14 total shoulder replacements and seven hemi replacements using the Biomodular system supplied by Biomet. Most of the patients undergoing a replacement procedure are in the 60-80 year age group. The procedure usually takes about 1.5 hours and the anaesthetist gives an interscalene block and sedation. Marcaine is given intraoperatively by the surgeon. All patients receive 1-2 litres of Hartman’s solution and 1gm Cephalothan intraoperatively, which is repeated 4 hours postoperatively. Pain is controlled using fentanyl or morphine IV but we have found that this is rarely required. The dressing is kerlix, combine and elastoplast. If the patient requires extended recovery, they are transferred to the local private hospital and usually only require an overnight stay but this may be dependent on family circumstances and patient mobility.

All these patients attend a preoperative clinic run by the surgeons in their rooms and are given very specific written pre and postoperative instructions that cover the exercise regime, the effects of the local anaesthetic, a pain control regime and contact information. All instructions are repeated verbally by the RN prior to discharge. The protocol varies slightly depending on the surgeon and/or anaesthetist. We believe that this type of surgery is very suitable for day surgery units and verbal feedback shows that careful selection and planning allows pain to be very well controlled. We will now carry out a formal quality audit of these patients as evidence of our success. We are all very proud of this achievement.

Quality initiatives

We have a personal assistant who assists with data entry for our quality programme. We collect the ACHS Day Surgery Clinical Indicators and our current quality projects are: patient, staff and surgeon satisfaction; time and variance studies; waste management and infection control audits internal/external; medical record audits internal/external; and satisfaction survey and audit of patients undergoing joint replacement and hemi replacement.

Future vision

Our activity rates are still growing and the future looks bright as we continue to expand. For the future we would like to develop services in gynaecology and general surgery.

Conclusion

It is important to us, at this point, to continue to support, encourage and develop our educational programme for staff. Day surgery is constantly progressing to more complex cases and it is extremely important that, to maintain a quality service, we must be aware of current trends and developments. Our highly motivated enthusiastic team, who work well together in the interests of our patients’ wellbeing and safety, achieves a great deal of personal satisfaction within our workplace.
Showcasing the day surgery unit

Paediatric Surgical Ambulatory Service, SA

Kasey-Maree Medlow • Clinical Nurse
Co-author: Cate Smith • Nursing Unit Head

Unit philosophy

The staff of the Paediatric Surgical Ambulatory Service (PSAS) are committed to providing the highest quality care to children and their families. We strive to achieve this high standard of care through:

• Evidence based practice to improve patient services.
• Education – to increase our knowledge base, using both formal and informal means.
• Shared knowledge from our diverse nursing experience.
• Evaluation of the team and the care we provide.
• Promotion of and working within the partnership in care model.

Introduction

In 2000 we had the opportunity to develop an ambulatory service at the Women’s and Children’s Hospital (WCH) in Adelaide, SA, now known as The Children, Youth and Women’s Health Service (CYWHS). It would incorporate the existing day surgery unit and the Campbell Ward which was a stand alone 18 bed ENT unit. The new development included a larger day surgery unit, a stand alone admissions area, and a short stay surgical ward encompassing many different surgical specialties. By 2002, PSAS was completed. It provides a streamlined patient flow area in an environment that optimises patient comfort and wellbeing. The PSAS unit includes a day of surgery admission (DOSA) area, day surgery unit and the Campbell Ward, a 12 bed short stay surgical ward.

PSAS is staffed with a mix of registered and enrolled nurses and also utilises assistants in nursing (3rd year nursing students). PSAS has a staff base of 16 FTE, which includes a clinical educator and a clinical learning coordinator to support the graduate nurses, shared across two surgical wards, and a clinical nurse with an allocation of non-clinical hours on a weekly basis.

PSAS is located on the same floor as the operating suite and the long stay paediatric surgical ward, so that patient flow from admission through to theatre and onto their postoperative destination is optimised. Day surgery is a free standing unit that covers all surgical specialties including ENT, orthopaedics, gastroenterology, plastic surgery, ophthalmology, urology and some medical specialties. The Unit is also utilised to manage two weekly clinics – the Intragram clinic for children with immuno-deficiencies and the burns day clinic, for those children requiring sedation and burn dressing changes. Children requiring steady state evoked hearing tests are also part of the day surgery patient case mix.

Demand on our services

Day surgery is a stand alone 20 bed unit and can accommodate up to 40 patients per day, divided into morning and afternoon theatre sessions. Patients stay for 1-1.5 hours postoperatively. The day surgery shift configuration consists of two nurses working 1000-1830, with extra assistance from floating shifts within the PSAS unit. There is also one full-time ward clerk that services both day surgery and Campbell Ward and a full-time play therapist for the PSAS unit.

Admissions from June 06 – June 07
DOSA – 5,625 patients admitted for surgery.
Day surgery – 3,478 patients admitted through DOSA and proceeded onto day surgery, where they were discharged.

Pre-assessment of patients

Patients and families are screened through an initial pre-anaesthetic questionnaire to identify any special needs related to their admission.
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Any patient that is identified as requiring further assessment pre-surgery is contacted by the elective pre-admission coordinator (EPAC) to discuss their individual needs. The EPAC also coordinates the admission of patients with complex needs. These patients are admitted at staggered times to ease the anxiety that can be associated with the whole hospital experience. The EPAC ensures that all essential requirements for individual children are organised prior to admission. Patients identified as an anaesthetic risk are assessed pre-admission a week prior to surgery.

Journey of care

The paediatric day surgery unit cares for children ranging from 12 weeks to approximately 18 years of age. Children are admitted through DOSA for morning and afternoon theatre. DOSA is staffed separately to day surgery, with three nurses, two administrative staff and the full-time play therapist.

Children are admitted through DOSA, with the area providing playful distraction for the children. DOSA provides a pleasant, interactive area where patients are prepared for elective surgery. The preoperative waiting area can cater for up to 50 patients per day divided over morning and afternoon theatre lists. Procedural and anaesthetic consents are completed within the DOSA area, ensuring all children proceed to theatre with fully informed consent. Preparation consists of a nursing admission, a comprehensive anaesthetic review and a clerical admission.

Fasting time for children undergoing elective surgery are:
- 0-6 months: 4 hours milk/food, 2 hours clear fluid
- 6 months+: 6 hours milk/food, 2 hours clear fluid

Children remain in the DOSA area until they are called to theatre. One parent/guardian may accompany their child through the anaesthetic induction. Having a parent present often alleviates anxiety for the child, resulting in an improved hospital experience. At the CYWHS we also foster the Partnership in Care model which encourages families to take part in the care of their child while they are a patient.

Following anaesthetic induction, the parent is accompanied by a volunteer through to the Unit. When surgery and initial recovery is completed, the child returns to day surgery for the remainder of their recovery period. Children remain in day surgery for a minimum of 1-1.5 hours or until they meet the discharge criteria set out in the newly developed day surgery clinical pathway.

The clinical pathway was developed to assist in the streamlining of children through DOSA/theatre/day surgery. It was developed to simplify the process of a day surgery stay by having the admission, postoperative and discharge information in one document rather than on multiple documents.

The pathway consists of a pre and postoperative checklist, which enables staff to clearly identify all relevant information to be discussed with the child and parent/guardian regarding their child’s admission and also includes a section which captures a follow up phone call made by nursing staff following the day of surgery. During the pathway’s 12 month trial, the nursing staff provided feedback on changes that needed to be made. These changes were implemented and finalised prior to evaluation that identified the admission process to be logical and time efficient. It also prompts staff to discuss all aspects of discharge care prior to the parent/guardian signing the acknowledgement of information at completion of their stay in day surgery.

Importance of play

Within the PSAS unit there are designated playrooms. The full-time play therapist works throughout all three areas within the unit. PSAS is very bright, comfortable and aesthetically pleasing.

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Prior to the redevelopment of the PSAS unit, new senior educational and support roles were created and funded to support staff throughout the development process and beyond. These roles remain in place today and include: clinical skills coordinator, clinical learning coordinator for GNPs and a clinical nurse for PSAS. The success of these roles is largely due to the physical location of the educators within the ward areas. This ensures that they are visible and highly involved with clinical care and considered an integral part of the team.

We promote a team culture and acknowledge staff regularly in the unit. PSAS rewards clinical excellence through recognition in hospital newsletters, ward meetings, nursing excellence awards nominations, customer/staff satisfaction acknowledgement, thank you afternoon teas and flowers or gifts for special occasions. The team nursing concept is visible throughout PSAS and it is a culture we instill into new staff coming to the unit.

In June 2007 the PSAS team received a staff recognition nomination for the efficient management of the weekly burns day case clinic that has recently been taken on within the day surgery area. Thorough education has ensured PSAS nursing staff are competent and capable in managing an efficient clinic.

Our future vision for our facility

Day surgery, as part of the PSAS unit, aims to apply evidence based nursing practice on a daily basis to become a leader in the provision of expert paediatric day surgery nursing care. Over the previous 12 months, PSAS has implemented several quality improvement initiatives including management of the burns day cases and the implementation of a day surgery pathway. As a unit we endeavour to continue this ongoing improvement cycle.

PSAS is renowned across the WCH campus as a great place to work. In PSAS we take pride in our team, values, beliefs, work habits and clinical expertise. We are continually evaluating our practice, staff and consumer satisfaction so that we know we are providing optimal nursing care. PSAS has the best working environment as it embraces and promotes fun while maintaining a professional outlook. PSAS has an effective education system, which fosters an environment that actively supports learning and professional development. All of these factors contribute to quality outcomes for our patients and the PSAS team.

This ability to constantly reflect and improve practice through open communication is proven by our constant positive recognition by consumers and other disciplines within the hospital.
Showcasing the day surgery unit
Pindara Day Procedure Centre, QLD

Jo Tier • RN, NUM
Allison Wilkinson • RN

Pindara Day Procedure Centre (PDPC) is a freestanding centre catering for patients who require a surgical procedure but who do not require an overnight admission to hospital. It is currently licensed to provide nine first stage recovery beds. Located 5km west of Surfers Paradise beach on the Gold Coast in sunny Queensland, the Centre is one of seven freestanding day surgeries on the Gold Coast. The Gold Coast is a fast growing region with a population of approx 500,000 residents; this is highlighted by the number of day surgeries in our region in addition to four public hospitals and three private hospitals. The services provided by PDPC are predominately accessible to the population of the northern region of the Gold Coast, although admissions also come from other parts of the Gold Coast, Brisbane and the Northern Rivers District of NSW.

In March 1998 a joint venture between Australian Hospital Care Limited and Surgicraft (a group of highly respected specialists), led to the design and building of this state of the art stand alone day surgery facility. The facility is located within the Pindara Private Hospital (PPH) grounds at Benowa and has some contractual agreements for service provision with them.

Accreditation of the facility was successfully initiated with ACHS within the first year of operation and has continued until recently. As a small facility, a more efficient and effective utilisation of our staff has been achieved by transition from ACHS accreditation to AS/NZS ISO 9001:2000 certification. ISO certification is widely recognised and utilised within the health industry and has allowed us to focus our emphasis on patient care and the achievement of positive outcomes.

Our facility
The facility has three well-equipped operating theatres, nine first stage recovery beds and 10 patient lounges in the discharge area. We currently employ 56 staff, using a mix of full-time, part-time and casual employees, covering nurses, orderlies, cleaners, reception and admissions staff plus accounting and CSSD personnel. Inclusive in the staffing numbers are dedicated full-time management and quality management positions. Our management system incorporates both environmental management and OH&S procedures that comply with all the current statutory regulations. This includes the certification of three staff who hold the positions of workplace health and safety officer (WHSO), workplace health and safety representative and a workplace rehabilitation coordinator.

The prime objective of PDPC is to provide quality healthcare in a safe, skilled, caring and supportive environment, which safeguards the privacy and rights of patients and their families. Further commitment by the organisational management team is the provision of a safe work environment for staff, visitors and their respective families.

Management of the facility is conducted via the Board of Management which consists of representatives from both of the owning bodies. The management team meets regularly on a bi-monthly basis and complies with all relevant legislation. Consultation in relation to clinical, ethical and professional conduct between the management and clinical teams is transparent and is facilitated via the Clinical Review Committee, which includes both medical and nursing representatives.

Specialties
Specialties provided at PDPC include orthopaedics, general, gynaecology, urology, ENT, plastic surgery, reconstructive surgery, IVF, oral and dental surgery and endoscopy. Session utilisation remains consistently high since opening and demand for session availability is competitive. Daily throughput can be up to 50 patients per day, with an average of 25 per day.

The commencement of IVF procedures has been the only additional new specialty to the services since opening. Demand for this service was recognised and has been included within the gynaecological services. Sperm aspirations and testicular biopsies are included within the urological services and are in direct liaison with the IVF laboratory.

PDPC caters for both adult and paediatric patients over 12 months. Initial admission booking processes are undertaken successfully via our 1800 phone line, with admission times being staggered to avoid lengthy waiting times for patients. The phone line is primarily utilised for patients to confirm bookings and attendance and also for the provision of the patients’ financial and health fund details.

Pre-admission
Information on special requirements, medical conditions, medications and fasting times are provided by the specialists prior to admission via submitted patient lists. Patient details, information and procedure details are entered into the computer network and are accessed by the reception staff for pre-admission procedures and compilation.
of surgical lists. The specialist also provides the patient with an admission information brochure, which includes information on their rights and responsibilities, fasting requirements and a pre-admission health assessment questionnaire. All pre-assessment interviews are conducted by the specialist in their rooms and, if necessary, patients may be referred to an anaesthetist for consultation prior to admission. Patients complete their own medical questionnaire, which is reviewed by the nurse on admission.

Day of surgery/procedure

Patient details are confirmed on admission by the reception staff followed by a nursing admission. The nurse is responsible for checking all patient details and patient consent before the patient changes into theatre clothing. Personal items are placed in a secure locker and the patient is then escorted to the waiting area, where they wait for interviews by the anaesthetic nurse, surgeon and anaesthetist. A TV screen has also been included in our preoperative waiting area to provide a calm and settled environment for patients while they wait for their procedure.

The procedure/surgery is performed in one of the three operating theatres of the facility and once completed, the patient is transferred to the recovery area. All surgical instruments are processed on the premises by CSSD technicians and endoscopes are processed by specially trained nursing staff.

Recovery and discharge

Patients are required to remain at the facility for a minimum of 1 hour following administration of any sedative/narcotic drugs. The time spent in the first stage recovery depends on medical condition, the type of anaesthetic administered, the type of surgery and the conscious state of the patient. This is assessed by a scoring system. Patients are transferred to the discharge lounge when they are fully awake and orientated, their observations are stable, pain and nausea are controlled and there is no evidence of bleeding. A comprehensive discharge criteria is utilised to determine patient discharge. Any patient not meeting the criteria is detained until met. Should admission to an overnight facility be required, this can be arranged in consultation with the treating medical officer and the anaesthetist.

We have recently provided a more private setting for our patients in the discharge lounge by installing flat screen TVs and transportable privacy screens. A choice of food and refreshment is available and dietary requirements are taken into consideration. Follow up appointments are made by the nurse and the carer is advised of discharge time. Discharge takes place once all discharge criteria are met. Verbal and written discharge instructions are provided to the patient and carer. This information consists of an instruction page provided by the specialist, with emergency telephone numbers and general post-anaesthetic and surgical/procedural instructions. Discharge medications are given by prescription and, if prosthetic or supportive aid is required, these are made available.

Quality activities

The recovery nurses conduct follow up phone calls on all patients the day following discharge. The patient is asked how they are feeling, their pain status, wound status and nausea, and if they have any other problems or concerns. Patients are also asked their opinion on the care they received and if there is anything further we could have done to improve their care and stay at the facility. Where unexpected or worrying symptoms are noted, the patient is advised to contact the surgeon or the anaesthetist, or can be directed to present to the emergency department of their local hospital. All follow up phone call information is recorded and reviewed as part of the ongoing quality management process.

Further patient care and satisfaction information is collected via random patient satisfaction surveys carried out bi-annually. Data are collated and results disseminated to staff. Data are further utilised within the quality management process for the continual improvement of patient services and nursing practice.

Keeping up to date

Education is a priority in our facility – all staff are encouraged and supported to attend workshops, conferences and seminars. Internal education programmes, in addition to the mandatory education requirements, are undertaken. Staff are actively involved in the State and national day surgery association meetings. PDPC conducts an annual 1 day clinical meeting where local medical specialists are invited to present topics of interest. An invitation is extended to all perioperative nursing staff in day surgeries and operating theatres from Gold Coast hospitals. The facility is also involved in the supervision of university nursing students during their practical hospital rotations.

PDPC has become a centre of excellence for the delivery of day surgery services. In addition to patient care service commendations from authoritative bodies, business outcomes are successful. We wish to take this opportunity to invite anyone when visiting the Gold Coast to call in and have a tour of our facility.
Abstract submission opens on Friday 25 July 2008.


Submission instructions will be available from the Congress website.

Abstract submission deadline Monday 2 March 2009.

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Showcasing the day surgery unit
Royal Hobart Hospital Day Procedure Unit, TAS

Gina Cook • Nurse Unit Manager

Introduction
The Day Procedure Unit at the Royal Hobart Hospital is a purpose built integrated unit which opened in 1994. It comprises a day surgery unit (DSU) and an endoscopy unit that share facilities and is situated in Liverpool Street, Hobart.

This review describes the DSU section. The unit services all of southern Tasmania and offers every surgical speciality except cardiac, thoracic, obstetrics and neurosurgery. It is located on the same floor of the hospital as the main operating theatre suite, which covers the additional specialties.

Structure and staffing
The unit has a patient admissions area, two operating rooms (OT), a procedure room and a third stage recovery room that also incorporates a paediatric second stage/third stage recovery room. The recovery room consists of five first stage (1:1 nurse ratio) recovery beds, six second stage recovery beds (approx 4:1 nurse ratio) and 13 third stage recliners (approx 4:1 nurse ratio). The third stage recliners are shared with the very busy endoscopy unit. All clinical areas have easy access to computerised network facilities.

The governance structure of the unit is that it is part of the division of surgery – perioperative services. The operational manager of the unit is the nurse unit manager with assistance from the medical director of day surgery and a full-time nurse floor coordinator. The unit has 36 clinical staff members who work on a full- and part-time basis. Of these 36 staff members, nine staff are employed on a full-time basis, the remainder of staff are part-time. There is also one full-time graduate nurse rotating through all areas of the unit over a 6 month period. There are seven ancillary staff, which include clerical staff, hospital aides, support services officer and a theatre orderly.

The perioperative services department is very proactive in relation to staff education. Once a month half day sessions are conducted for all perioperative services staff – attendance is compulsory. The DSU has been allocated a part-time clinical nurse educator and skills facilitator who, in collaboration with the main operating suite educators, organises study sessions that include guest speakers and provides personal development opportunities for all staff. The education staff have also developed an excellent orientation programme with a specific focus on day surgery.

Activity
Our current percentage of surgery that is managed as same day surgery is 54%. In winter months this has been as high as 69%. Our DSU has consistently increased services since opening in June 1994. We originally offered minor day surgery as same day surgery but have now progressed to offer services to all the following specialties including paediatrics, ophthalmology, plastics, facio-maxillary, general surgery, dental. ENT, orthopaedic, gynaecology and urology. We also offer some medical services in the form of transoesophageal echo, cardiac reversion, electro-convulsive therapy, botox injections for cerebral palsy children, chemotherapy – in the form of lumbar puncture methotrexate injections for paediatric oncology – and bone marrow harvesting for adult patients.

Procedures
Our unit averages 450 patients per month, which includes a high number of patients sent to DSU for discharge from the main operating suite and anaesthetised patients from the medical imaging department. Our same day surgical procedures have increased in complexity and in the level of patient acuity of those undergoing these procedures. The unit caters to all age groups from neonates to the elderly. We are currently open from 7am till 10pm. A recent extension of hours from a 7pm to a 10pm closure is an initiative to allow for the more complex surgical cases. This has also enabled us to improve the quality of post-anaesthetic care for these patients by providing a longer recovery time. It also allowed for more flexibility within the theatre lists, especially for the main theatre surgical patients requiring DSU postoperative discharge. The DSU is open 5 days a week excluding public holidays. As is the case with other hospitals, activity in the DSU is affected by factors such as staff availability and inpatient bed availability as well as ‘downtime’ over the Christmas and New Year period.

Patients are referred from outpatient clinics or from the surgeon’s private rooms. Request for admission forms (RFA) are filled out, with the consent signed at the initial consultation. Pre-admission clinic attendance, in the form of nursing or anaesthetic interview, is determined by the responses to the patient health questionnaire form in the RFA. The consulting doctor may also request an anaesthetic clinic consultation prior to the patient having surgery. Preoperative testing and workup is done at this pre-admission clinic following clinical guidelines. Once the patient has completed the RFA, it is passed on to a booking nurse in the pre-admission area who then assesses the information, confirms the details with the patient and
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the patient is then placed on the waiting list according to their category and urgency. The most major cases performed in the DSU as day cases are laparoscopic cholecystectomies, mastectomy and diagnostic paediatric laparoscopies. The average length of stay for these patients is 3.5 hours.

Operating lists are managed by liaison nurses who manage multiple surgical specialties. These nurses consult with surgeons, the NUIM and floor coordinator, anaesthetists, other appropriate hospital departments and the patients prior to an operating list being accepted as final. The patient then receives a letter advising surgery date and time, and is asked to phone the DSU the day prior to confirm their fasting requirements, health status and admission time. Admission times are staggered to reduce waiting times and to improve patient flow on the day of surgery. On the day of surgery the patient is assessed by the anaesthetist and surgeon to ascertain their fitness for surgery. Consent must be in place before the patient leaves the admission area.

On arrival, the patient has a clerical admission to the hospital and the patient’s history is passed on to an admission nurse who admits and prepares the patient for theatre. The patient is visited by the anaesthetist and surgeon and then taken to an internal waiting room, from which they can walk through to the OT with the anaesthetic nurse who conducts the first stage of the perioperative team’s ‘time out’ process. Once the patient is in the OT, the surgical team again conduct a ‘time out’ to check the correct operative site, correct patient, and correct equipment are available and consent is cross referenced.

Following general anaesthetic or sedation, the patient is transferred to first stage recovery. Patients who have local anaesthetic/sedation go directly from theatre to second or third stage recovery. The average length of stay for patients is 2–4 hours, depending on procedure.

Some paediatrics and major plastic cases may be admitted to the ward postoperatively, for example hypospadias repair and major skin grafting procedures. Our postoperative unplanned admissions have increased due to the complexity of cases and higher patient acuity. Patients must meet the Revised Post Anaesthetic Discharge Score criteria (based on PADSS, Chung, CJA 2006) prior to discharge, and are given written postoperative instructions specific to their procedure. Verbal postoperative instructions are given to both the patient and carer who must be present before discharge is allowed. Follow up phone calls to all day surgery patients are carried out the day after the procedure. This phone call incorporates a patient satisfaction survey and postoperative health survey.

Quality initiatives
Review of clinical indicator form

Our unit has reviewed the method we utilise to collate our clinical indicator data for ACHS. This has resulted in improved accuracy when determining the number of inpatients as opposed to the number of outpatients the unit was accepting. The form utilised now separates unplanned admissions into two groups — surgical versus anaesthetic grouping. This has resulted in the ability to accurately follow up the reasons for unplanned admissions and the ability to better determine the types of cases and specialties that need overnight beds. The form also incorporates the collation of the number of patient cancellations on the day of surgery, patients that do not arrive, unplanned admissions, planned admissions, patient throughput and one extra indicator for collation — patients cancelled due to fasting issues.

Perioperative services have developed an improved post-anaesthetic chart with highlighted parameters to indicate criteria for calling the medical emergency team (MET). Colour-coded reportable limits in the post-anaesthetic record represents any deterioration in patient observations. The postoperative anaesthetic record allows the anaesthetist to record acceptable variation of patient observations prior to a MET call being implemented. A first stage discharge scoring system is also included on the form.

Preoperative warming policy

The unit has a temperature criterion that patients must meet on admission. If the patient fails to meet this criterion, then measures are taken to increase body temperature prior to surgery.

Recovery room competency

Recovery staff must be first stage trained and have completed recovery room competencies. These competencies are conducted annually and staff are randomly audited 6-monthly.

Performance development agreements (PDAs)

Perioperative services have introduced a mandatory performance development agreement (PDA) with all staff. These meetings are conducted annually and, during PDA, staff are encouraged to undertake a quality initiative, e.g. a new policy developed and implemented on the post-procedure management of ECT patients.

Postoperative appointments

A booking sheet template is utilised for each surgical specialty for the purpose of streamlining the process for follow up appointments. This ensures that patients have follow up appointments arranged; this is evident in the reduction of non-attendance at postoperative review.

Nursing documentation audits

Nursing documentation audits are mandatory and conducted twice a year, resulting in an improvement of the level of documented patient history in the medical record.

Future vision

The unit has recently extended the operating hours, which have resulted in more flexibility within operating lists and making recovery times not as restricted. We are currently targeting surgeons and anaesthetists to allow this service to be fully utilised, resulting in greater patient throughput and safer clinical practice. The other advantage to the extension of day surgery recovery room hours is that acute ward beds are not taken up by day surgery patients. We are considering the implementation of a 23 hour unit in the future and are currently working towards this endeavour.

Our main challenges include: staffing, succession planning; throughput limitations by space constraints; an increase in waiting lists; more complex day surgery; evaluation of extended hours initiative; implementation of 23 hour unit; and planning for new day surgery facilities in a new replacement hospital.
Showcasing the day surgery unit

Sir Charles Gairdner Hospital Short Stay Unit, WA

Lynda Harrison • Nurse Manager
Claire Kennedy • Clinical Nurse Specialist

Sir Charles Gairdner Hospital is situated in the south west of the city of Perth and is well acknowledged for its standards of excellence in patient care, teaching and research. It is one of the country’s largest public teaching hospitals, caring for the local community as well as patients who are referred from throughout Western Australia, interstate and overseas for specialist treatment. It is accredited by the ACHS.

The short stay unit (SSU) was established in its current geographical area 10 years ago. At that time it was most definitely a state of the art unit. Throughout the last 10 years, the unit has travelled an interesting journey of both change and excitement as it has progressed from a dedicated day procedure unit, catering for a broad range of surgical and medical procedures and covering a multitude of specialties, to an area that now incorporates both day procedures and post-surgical overnight stay beds. We are located in the main block of Sir Charles Gairdner Hospital within close proximity to the operating suite (OT).

Our vision is “To be renowned for the excellence of our work”. Our values are that “We value our patients as the most important people in the hospital. We value our staff, strong leadership, teamwork and best practice”.

The authors are responsible for the day procedure unit and also for managerial and clinical issues in the pre and post acute care services. This includes day of surgery admissions (DOSA) and the pre-admission clinic (PAC). These areas are not officially a part of the SSU; however, they need to work closely together to ensure a smooth pre and postoperative experience for patients.

In January 2008 we renamed the area ‘SSU’ when we amalgamated the day procedure unit with DO23/DO47 (Day of Surgery Admissions staying 23 or 47 hours). It is best if we describe these areas separately.

Day procedure unit

This area comprises the following:

- A designated reception area with an admissions clerk and receptionist. The patients are clerically admitted and then wait in chairs for a nursing admission.
- Three individual consulting/interview rooms, utilised to complete all nursing paperwork, phlebotomy and recording of baseline observations. They are also available for the medical and anaesthetic staff for patient consultations.
- Male and female change rooms.
- Six perioperative trolley bays and several recliner chairs that are utilised for patients awaiting procedures under local anaesthesia (LA).
- A six bay recovery room staffed by the SSU nursing staff. ACORN Guidelines are followed and the setup emulates that of main recovery. The benefits of this are related to a safe environment for all staff if they should work across both recovery areas. Our recovery accepts all patients postoperatively for DPU and DO23. Due to the enormity of patient numbers and only six bays, the DO47 patients are recovered in main recovery.
- Eight second stage recovery trolley bays. All patients are cared for postoperatively here and discharged from these bays.

The day procedure unit plays an important role in assisting to decrease the surgical waiting list in Sir Charles Gairdner Hospital. It has the capacity for a throughput of approximately 34 patients between the operation hours of 0645-2030 Monday to Friday. We are closed for all public holidays.

Staffing

Each day is staffed with a combination of registered nurses, advanced skilled enrolled nurses and graduate nurses. Each area has two staff, giving a total of 10 per day. Within this 10 there is a dedicated shift coordinator who does not carry a patient load (Total FTE = 14.54).

Preoperative assessment

Patients under the age of 60 receive a preoperative telephone call from nursing staff in preoperative assessment clinic (PAC) to evaluate the need for a more in depth assessment. The majority of these patients require no further assessment and are directly admitted on the day
of surgery. Patients over 60 with co-morbidities are allocated an appointment in PAC within the 2 weeks prior to surgery.

Contact

All patients receive a telephone call the day before surgery to inform them of their fasting and arrival times. This is also a valuable opportunity for the patients to ask any questions regarding their procedure or medications.

Discharge

All patients receive verbal and written postoperative instructions in the form of a pamphlet. The following day they receive a telephone call from nursing staff to ensure they are recovering without complications. This provides us with statistics that enable us to periodically review our practice, ensuring we are providing best practice at all times. Clinical indicators are also collected.

DO23/DO47

In 2000, as a winter strategy, 10 beds were opened for overnight stay in the day procedure unit. This operated from Monday till Friday to assist with the increased demand for beds for elective surgery. This proved so successful that the beds were increased to 15 in 2005 and increased to 22 again in 2007 and now accommodates a stay of 47 hours. The operational hours also increased from Monday through to Saturday afternoon. This increase has given us the ability to care for up to an additional 1,000 patients per year (Total FTE=26.71).

Each day is staffed with a combination of registered nurses, advanced skilled enrolled nurses and graduate nurses and a dedicated shift coordinator who does not carry a patient load. Staffing consists of five nursing staff each morning and afternoon and three permanent night duty staff. One resident medical officer is available to liaise with the surgical teams to expedite early discharge and to care for medically unstable patients. We have a ward based pharmacist as well as other allied health cover. The staff here also enjoy the benefit of the unit being closed on Sundays and public holidays.

Preoperative assessment

All patients admitted to DO23/DO47 postoperatively will have attended a routine PAC appointment within 2 weeks preoperatively.

At this appointment they have a full nursing assessment, phlebotomy, ECG as required, a full anaesthetic review, a medical team admission and the suitability of the patient for the overnight stay unit is assessed.

The area is structured differently to the standard ward layout. It is an open plan ward with the provision of communal ablution facilities. The patients need to be relatively ambulant and self-caring other than their surgical limitations. This ensures that they can be discharged in a timely manner as planned. We are then able to receive the following day’s surgical allocation without impeding the flow through the OT.

Contact

All patients for this area receive a telephone call from the nursing staff in DOSA the day prior to admission, informing them of fasting and arrival times. It also enables the patients to ask any questions they might have. All patients for the overnight stay area are admitted day of surgery through DOSA.

Discharge

Discharge is encouraged to be before 1000. When a patient is reviewed and deemed suitable for discharge, the carer is contacted to collect the patient. The hospital has a discharge lounge to assist with clearing the area in a timely manner. All patients receive verbal and written postoperative instructions. We are in the process of initiating clinical indicators for the overnight stay area.

Conclusion

We are fortunate to have a dynamic and successful unit encompassing many facets of short stay surgery. Our staff are the backbone of our unit, their commitment and dedication to succeed and rise to all challenges is a credit to them all.

We are sure that, as the requirement to continue to reduce the length of stay increases, we will find that once again we will encounter further expansion of our facility and a greater reduction in postoperative care times for more specialties. The ability of our team to embrace this with enthusiasm is what makes us a popular and successful benchmark.
**Book review**

**Fluids and electrolytes demystified: a self-teaching guide**

*Author:* Joyce Y Johnson, PhD, RN  
*Available from:* McGraw Hill 2008  
*Cost:* $34.95 incl. GST  
*Reviewer:* Helen Taylor MN, RN

The author clearly states in her introduction that *Fluids and electrolytes demystified* is a detailed overview of the topic only; it is not designed to be a comprehensive coverage of fluids, electrolytes and acid-base balance or imbalance.

Each chapter begins with a list of learning objectives, key terms, a brief overview of the chapter and finishes with a set of NYCLEX-style questions. The chapters are well presented with cues to each objective as it is answered in the chapter plus diagrams and tables as necessary. The language used is straightforward and key concepts described well. The test questions are a good gauge for the reader to determine their understanding of the topic prior to moving onto the next chapter.

Overall, I found this text easy to read whilst providing straightforward information on the subject. Each topic is clearly outlined and each chapter is referenced to allow the reader access to more in depth information.

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**Clinical reviewers**

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<tr>
<th>Name</th>
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**Australian Day Surgery Council report**

Maralyn Masters and I attended the Strategic Planning Seminar held on 5 April at the Stamford Hotel, Sydney Airport. We were well represented as there were other ADSNA members wearing ‘different hats’, with Michelle Birks (Victoria) representing the ANF and Celia Leary (NSW) as RCNA representative.

The aim of the seminar was to discuss the issues and set goals the ADSC wish to achieve through teamwork and was facilitated by Kerin Williams who facilitated the previous Strategic Planning Seminar in 2002. All council members were given the opportunity to respond to a questionnaire prior to the seminar to indicate how they felt that the ADSC had achieved the goals set out in 2002. This feedback became the base for discussion and planning in order to develop the Strategic Plan for 2008-2011. Once again, the contribution that the nurses make at the Council level was affirmed and appreciated.

The Strategic Plan is available on the ADSNA website. Once again, I am very happy to respond to any further questions or concerns regarding the ADSC.

Wendy Adams  
Email: president@adsna.info
State reports

New South Wales

As I write this, there are loud claps of thunder, which I presume will be followed by rain tonight. As it has been dry for some time now, it will be good to get the grass watered again.

Since my last message, we have had two very successful educational events. In February, Castle Hill Day Surgery hosted our evening session and we had a very good attendance of members. The topic for the night was laparoscopic cholecystectomy and the speakers gave an excellent insight into their procedures and protocols. A light supper and a tour of the unit followed. Thank you Castle Hill for sharing this information with us and welcoming us to your unit.

In May, five of the committee travelled to Tamworth for a half day seminar, Day surgery in the Bush, at Tamara Private Hospital. Once again, we had a very good turnout and were made very welcome. The topics were varied and very well presented. Regardless of what educational event one attends, there is always something to learn from it and it is so good to network with colleagues from outside the city boundaries. Morning tea and lunch were provided and some members took the opportunity to tour the unit. Thank you Tamara for a great day; we thoroughly enjoyed our visit.

We have been very focused this year on the organisation of our conference and we are now into the final stages where most of the work is done. We look forward to seeing lots of our members register and come along. We have a programme that should be of interest to all, regardless of the particular area they work in. Our speakers are all experts in their field, so we are looking forward to the day being highly successful. We also have had an exceptionally good response from trade, so be sure not to miss out!

There are a few committee members standing down from the committee this year, therefore we will be looking for volunteers to take their place for the coming year. The AGM will be held at the end of the programme and we trust that all members will attend, as this is your opportunity to make comments and suggestions to the new committee. And, as always, if their are any budding authors out there, we would like to hear from you as we are continually looking for articles for the journal. If you want to keep up to date on our activities be sure to visit our web page at www.adrna.info

The weather has now progressed to thunder, lightening, hailstones, rain and wind! Best regards to all.

Celia Leary, President

Queensland

How time flies when you’re having fun! This year seems to be going past quicker than ever, and we have had an exciting first half of the year with DSNAQ.

The committee is working hard to make the conference in September a great one. The venue is again on the Gold Coast at the Crowne Plaza Hotel, in Surfers Paradise. The programme is looking sensational for all, including IVF (controversial issues), ecco waste, tonsillectomies in day surgery, fess in day surgery, bariatrics, pain management in day surgery and extended stay in day surgery. Also included is a 2 hour networking session following the conference.

The meeting in Mackay at Mackay Base Hospital was fantastic – what an innovative and motivated group of day surgery nurses! 11 people signed up as new members, making Queensland membership very healthy. Thank you to 3m and Invitro for their support of the meeting in Mackay, it is great to see the trade support in regional areas.

In July we had a very successful Education Session at John Flynn Hospital on paediatric ALS; thank you to Denise Airey from Healthcare Training Services and once again to all those that attended and supported education for nurses.

We would really appreciate hearing your ideas for education sessions. DSNAQ is here to support education for day surgery nurses. There are many areas of day surgery, pre-admission, day of admission, discharge for day stay patients, free standing day surgeries, paediatric day stay, PACU first, second and third stage, and many types of surgery, so it is important that your ideas are put forward.

In 2009 we will not be holding our Annual Conference as Brisbane is hosting the International Ambulatory Surgery Conference in July. But we will again be taking our educational sessions regional, as we hope to head to Townsville or Cairns, possibly Hervey Bay and Toowoomba as well, and we look forward to seeing many of you. Don’t forget to check out the website for all information on educational sessions, the conference programme, and registration forms.

I would also like to encourage all members to consider becoming part of the committee. It is a great place to share knowledge and network with your peers; the feeling of achievement for both freestanding and integrated day surgery units has only helped my day surgery unit become an even better place. The AGM will be held at the conference and, remember, many hands make light work! Regards.

Jo Tier, President
Tasmania

Tasmania has had a quiet time over the last few months. We had a meeting at St John’s Hospital which was attended by members from around the State. A tour of their day surgery unit followed which was very exciting. We thank Calvary Healthcare Tasmania, Roxanne Hooper-Waters and Sandy Foster for organising the day... not to mention the food!

Again, full steam ahead for the planning of the ADSNA Tasmanian branch conference which will be held on 23 August. Please log on to the ADSNA website for more details. The conference committee has been extremely active. Sponsors have been forthcoming and committed to our conference, which is absolutely wonderful. The programme this year will incorporate the sterilising side of nursing, since SRACA will be joining ASDNA this year; welcome to the SCACA members who hopefully will enjoy our conference. The title for this year’s conference is On the right track which covers a broad area of nursing which we will endeavour to mention in our programme.

Please remember that there will be an Annual General Meeting at the Reading Room at Ross on 26 July 2008. The President’s position is up for re-election – nomination forms are available on the website. The Executive Committee remains the same, with the Treasurer and Secretary. I have thoroughly enjoyed my time as President of the Tasmanian branch and I know whoever will be the new President will carry the banner high as always. Thank you,

Fiona Svamvur, President

Victoria

2008 has been a very busy and exciting year for DSSIG. We have had a Twilight Meeting at The Alfred Centre and a Combined Groups Seminar with ASPAAN, PaNA and VPNG as well as our 11th State Conference at The Hilton on the Park. It has been a fabulous opportunity to catch up with so many of our colleagues from around the State.

But, there is more... we still have a combined Twilight Education Session and Annual General Meeting at Victoria Parade Surgery Centre on 19 August and our Twilight Education Session and Christmas Party at Sunshine Hospital DPU on 18 November. We look forward to seeing you all again.

Finally, our new venue for our executive meetings this year at the ANF Conference and Education Centre in the city has had to be changed due to renovations. However, we are committed to meeting at venues that best suit our committee members so that we can have committee members from all around Melbourne. Please don’t hesitate to contact us if you would like to join this dynamic group. Names and contact details of all our current committee members can be located on the Victorian page of the ADSNA website. www.adsna.info

Wendy Adams, President

Western Australia

The past 3 months have been very busy for the committee in Western Australia. The constitution has been reviewed and updated and will be tabled at the next meeting.

The study day in Geraldton, held on Saturday 24 May, was a great success. The theme for the day covered many topics and included correct site surgery, nurse led pre-admission clinics, implementation of a risk tool to prevent deep vein thrombosis, anaesthetic drug impact on epileptic and Parkinson’s patients and creating a positive work culture. Community outreach projects, ENT services to remote Aboriginal communities and volunteering in Tanzania, gave the participants the opportunity to gain knowledge of the work being done to improve health and wellbeing of isolated communities. The nurses who travelled from Perth were able to meet and network with nurses who work in country hospitals.

The evaluation of the day provided the committee with many ideas and challenges for the next study day. I wish to extend my thanks to the hard working committee for their support and hard work that resulted in an enjoyable road trip.

The West Australian committee is working hard to encourage nurses to attend the International Conference in Brisbane 2009 to ensure a strong contingent from Western Australia.

Gillian Rimmer, President, NASSF WA

Ambulatory Surgery is now available on line at no cost!

Ambulatory Surgery promotes and develops this system of patient management by providing a multidisciplinary international forum for all those healthcare professionals involved in day-care surgery. The journal publishes peer-reviewed original articles relating to the practice of ambulatory surgery.

Papers are included on:
- Basic and clinical research – in surgery, anaesthesia and nursing
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Also included are topical and educational reviews examining a wide range of subjects and controversies in the field.

www.ambulatorysurgery.org
Diary dates

Note: Updated information on diary dates can be found on the website as details for meetings are arranged. All States will send out flyers as reminders closer to the date of the meetings.

**New South Wales**

16 August  
State Conference  
*Four Points by Sheraton, Darling Harbour, Sydney*  
8-5pm  
Contact: Celia Leary  
Tel: (02) 9603 1182  
Email: cdleary@zip.com.au

27 October  
Evening Education: Latest Trends in Urology  
*Campbelltown Day Surgery Unit*  
7-9pm  
Contact: Celia Leary  
Tel: (02) 9603 1182  
Email: cdleary@zip.com.au

**Queensland**

6 September  
DSNAQ Conference & AGM  
TBA, Brisbane

**South Australia**

22 September  
Education Sessions – Evening Session

10 November  
AGM/Evening Session

**Tasmania**

26 July  
AGM  
Ross

15 November  
State Meeting  
*Mersey Hospital, Latrobe*

**Victoria**

19 August  
Twilight Education Session and AGM  
*Victoria Parade Surgery Centre*  
Contact: Wendy Adams  
Tel: 0417 384 634

18 October  
Combined Groups Country Meeting  
Warrawgi  
Contact: Wendy Adams  
Tel: 0417 384 634

18 November  
Twilight Education Session and Christmas Party  
*Sunshine Hospital DPU*  
Contact: Wendy Adams  
Tel: 0417 384 634

**Western Australia**

12 August (including AGM)  
Monthly State Meeting  
*Sir Charles Gairdner Hospital*  
8th floor, Joske Lecture Theatre, ‘G’ block  
Contact: Bea Daniel  
Email: bea.daniel@sjog.org.au

14 October  
Monthly State Meeting  
Venue as above  
Contact as above

9 December  
Monthly State Meeting  
Venue as above  
Contact as above

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Information for authors

Submission of papers

We encourage anyone with an interest in day surgery to submit manuscripts on all aspects of day surgery for publication in our journal. Share with your colleagues your clinical experience, quality activities, innovative practices, advances in trends and developments, research studies and conference reports. Our journal is published three times per year. By publishing your activities, you can be part of the continuous growth of day surgery and best practice in our specialty.

Manuscripts are submitted electronically: go to the publisher’s website – www.cambridgemedia.com.au, click on Manuscript System, login to create an account or access an existing one and follow the prompts. Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review. You will be notified by email once your manuscript has been selected for peer review.

Submission deadlines

- 30 April 2008

You will be notified of receipt of manuscript and publication date by email. The Editor’s decision is final to publish or reject.

Peer review

All manuscripts submitted for publication are subject to independent review by at least two peers to assess accuracy of fact, clarity of presentation and use of references. Following review, the submitting author will be notified by the editor regarding acceptance or rejection of the article. Please note that assistance will be provided to prepare manuscripts for publication where deemed appropriate by the editorial board. All articles accepted for publication are subject to normal editing procedures. Minor changes to grammar will be made without notification to the author.

Preparation of manuscripts

A copy of the manuscript should be submitted to the Editor as an email attachment. The manuscript should be written using double spacing with wide margins, and in size 10 Arial font. A head and shoulders photograph of the author is required (refer to illustrations re format).

A covering letter must also be submitted as an attachment and should contain:
- Author’s name and address.
- Business and home telephone numbers.
- Contact email address (and alternative if appropriate).

Referencing

References within the text should take the form of a superscript number at the point of reference and then in a numbered list at the conclusion of the text. This should appear consecutively. All listed references must be cited in the body of the text and communications and unpublished data should be in parenthesis; they should not appear in the reference list.

References follow the convention of the Vancouver system:

Standard journal article – list all authors

Books and other monographs

Conference proceedings

Illustrations

Each table and figure must be presented on a separate page following the reference list. Tables and figures must be numbered in the order they appear in the text.

All artwork should be submitted electronically where possible. All electronic photographs must be scanned at 300dpi. CMYK and submitted as .jpeg. Computer generated charts, tables and graphics are suitable but hard copies may need to be forwarded at a later stage (Editor will advise). Permission to reproduce illustrations must be obtained by the author from the owner of the copyright, usually the publisher.

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