JUST FOR THE DAY

By Rosemary Thornes
on behalf of

Caring for Children in the Health Services

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Children admitted to hospital for day treatment

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Caring for Children in the Health Services (CCHS)

Was founded in 1985.

The parent organisations are:

Royal College of Nursing of the United Kingdom (RCN)

British Paediatric Association (BPA)

National Association of Health Authorities and Trusts (NAHAT)

National Association for the Welfare of Children in Hospital (NAWCH)

CCHS has published the following reports:

Where are the children? (1987)

Hidden children (1988)

Parents staying overnight with their children in hospital (1988).

For the purpose of this Enquiry CCHS has **co-opted representatives** from the British Association of Paediatric Surgeons (BAPS), the College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland. Mrs Tessa Brooks, Director of the Quality Improvement Programme, King's Fund Centre, was co-opted in a personal capacity.

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Introduction

1a. BACKGROUND TO THE ENQUIRY AND INTRODUCTION TO THE REPORT

The parent organisations of Caring for Children in the Health Services (CCHS) represent several disciplines. This encourages the development of a multi-disciplinary view, but at the same time we try to ensure that the child remains the focus of our discussions. The Committee's main aim is to look at ways of improving the quality of care for children.

We started this Enquiry in the belief that admitting children as day patients was an excellent way to provide good care, based on the philosophy of keeping children safely within their families, with the parents remaining the principal carers. We have concluded our work still firm in this belief, but with an even stronger conviction that day admissions have to be carefully planned if they are not to cause unnecessary stress to children and their families.

PURPOSE OF THE ENQUIRY

CCHS is very concerned that, in a time of considerable change, guidance on the establishment of a children's day case service is limited and advice on the delivery of care very scattered. With this report we aim to provide a managerial tool for hospitals to help them improve the quality of their care. We hope the report will prove useful, for both purchasers and providers of child health care, in the preparation of NHS contracts. To this end we have identified a comprehensive set of quality standards for day cases, including pre-admission, transfer of care and post-discharge care at home. We have also looked at different patterns of provision and make suggestions on how hospitals can adapt the standards to fit their local circumstances. Future developments have also been incorporated into the discussion, in the light of the proposals outlined in Working for Patients and subsequent documents (Secretaries of State for Health, Wales, Northern Ireland and Scotland 1989).

METHOD OF WORKING

The information on which this report is based has been derived from two main sources. Firstly we carried out a review of published literature; readers interested in further reading are directed to the selected bibliography in Part 6. Secondly we requested evidence from the Royal Colleges, professional and voluntary organisations, individual consumers, health authorities, selected hospitals and many independent experts. The response was tremendous, from every type of organisation and from all parts of the United Kingdom. 230 written submissions were received and discussed at monthly meetings of CCHS (see appendix III for list of submissions). The Committee also took oral evidence and members attended seminars and visited hospitals.

THE CURRENT SCENE

Our Enquiry was designed to recommend good practice, not to survey what is happening at present. However, in the course of the project a picture of present-day practice has emerged and we offer the following observations of the current scene.

In hospitals where day case facilities for children are working well, they have usually been initiated and are sustained by enthusiasts. Elsewhere, many problems are caused by children and adults being cared for together, by major and minor cases being on the same operating lists and by day cases being mixed with inpatients on the wards. In most hospitals there are no special day case facilities for children and the service is fragmented or inpatient facilities are used. There are inadequate numbers of clerical staff of the right quality. Child day patients are rarely monitored and audited separately from adult day cases or from inpatients.

There is inadequate forethought for the needs of day patients as a discrete group, with few separate operational plans and poor information for parents; too often children have to stay in hospital overnight. The delivery of care is frequently based inappropriately on inpatient goals.

Since 1959 Department of Health policy has been to

gather children into a comprehensive children's department. The evidence received reveals an anxiety that this welcome development may be jeopardised by the expansion in day surgery.

THE PLACE OF DAY CASE ADMISSIONS IN CHILDREN'S HEALTH CARE

For diagnosis

Both paediatricians and surgeons increasingly arrange tests on a day basis. Even with the increasing sophistication of the diagnostic equipment, tests can normally be fitted into a day, especially if the parents supervise the preparation of the child at home, for example by means of starvation or special diets. Other examples are timed tests on the ward or a series of tests that have to be co-ordinated so that the child is distressed as little as possible.

For medical therapy

Much therapy can also be arranged on a day basis. This can be particularly valuable for children with a chronic or long-term illness, such as cancer or cystic fibrosis, whose care is increasingly carried out at home.

For surgery

Day admission is appropriate for many surgical procedures. The Royal College of Surgeons of England (RCS 1985) has published guidelines to encourage surgeons and health authorities to undertake more day surgery. A few health authorities have established well-organised programmes, so that 50% of the general surgery of childhood is carried out on this basis (Atwell and Gow 1985). A large proportion of ear, nose and throat (ENT) operations are done on a day basis and other specialties such as ophthalmology, orthopaedics and urology have procedures that are considered safe for day treatment.

DEVELOPMENTS IN DAY SURGERY

In recent years the government has put forward economic arguments for the increase in day surgery (Department of Health 1989). Many clinicians have been worried about making changes for purely financial reasons. However, it is now generally recognised that resources will never be entirely adequate and day surgery does offer one way of providing an equally good or even superior service when it is well-accommodated, well-equipped and well-organised.

During 1990 interest in the surgical aspects of day case admissions flourished and the British Association of Day Surgery was founded. Its aim is to promote high quality day surgery in the United Kingdom, and the Association has stated that it plans to include all client groups, including children (British Association of Day Surgery, personal communication).

Many regional health authorities have set targets for surgical day admissions, and in most cases these will involve considerable expansion of numbers. Unfortunately not all have separated out children in the surgical specialty targets.

In recent years the number of surgical day cases has grown fairly rapidly according to Departmental statistics (Department of Health 1990b). Hill (1988) and the Audit Commission (1990) query the quality and accuracy of the data, though there is no question that suitable accommodation and facilities for adults continue to grow. However, for children the growth has been extremely patchy. One hospital reports that it carries out 60% of its paediatric surgery on a day basis. Another children's department in a district general hospital states that approximately 80% of its waiting list admissions are admitted as day cases. Yet it is believed that the level of day surgery for children, as a proportion of all children's surgery, falls below 10% in many districts. A recent survey has produced data for particular procedures for children aged 0 to 15 years, in a sample of 54 districts: for inguinal hernia repair the proportion carried out on a day basis is 29.3%; for circumcision 38.3%; for orchidopexy 17.4%; for squint correction 2.7%; and for myringotomy 55.4% (Audit Commission, personal communication). These figures are surprisingly low, considering the encouragement provided by the Royal College of Surgeons of England (RCS 1985).

Children appear to be ideal patients for day admission. Unlike many adults, they always have someone to accompany them and continue the care at home. The reasons for discrepancies between districts are not immediately obvious. Many surgeons seem to view with caution the change in practice which the management of children as day cases entails. This may be because children form a small part of the work-load of many general or specialist surgeons, and they have little opportunity to build up an expertise in children's surgery (Campling et al 1990). Few districts have paediatric surgeons

RECENT REPORTS AFFECTING DAY SURGERY

The government continues its interest in day surgery. In 1990 the Value for Money Unit of the NHS Management Executive carried out a study to analyse why the levels of day surgery fell significantly below those regarded as possible by the Royal College of Surgeons. It looked at cost implications of different patterns of day surgery, obstacles to increasing day

surgery and key features necessary to support day surgery (NHSME to be published 1991). Children were included in the study.

In 1990 the Audit Commission also carried out a study of day surgery as part of its role of auditing the NHS. It dealt with costs, management practices and quality of service (Audit Commission 1990). It advised that specialist day case units should be provided in all districts and if possible a dedicated operating theatre should be added. Advocating an awareness of children's special needs, it suggested that sessions in the general day case unit should be dedicated to children in those places where separate children's day case facilities could not be justified. It was not in favour of using the children's inpatient ward for day surgery.

In 1990 the National Confidential Enquiry into Perioperative Deaths (NCEPOD) completed its review of the surgical and anaesthetic care of children in hospital. Day management was included in this study and the report's recommendations are of importance for day surgery. They advised that surgeons and anaesthetists should not undertake occasional paediatric practice and that consultants who take the responsibility for the care of children (particularly in district general hospitals and in single specialty hospitals) must keep up to date and competent in the management of children. They mentioned the lack of appropriately trained nurses (see Part 1b) in some units and deplored data systems in which children could not be identified easily (Campling et al 1990).

MEDICAL DAY CASES

As far as medical paediatrics is concerned little has been published in recent years on day case admissions. In his study of ward attenders in Mersey Regional Health Authority, Hayhurst (1988) found that staff had difficulty in differentiating ward attenders from day cases and he recommended that less emphasis should be placed on use of a bed and more on procedures and length of time on the ward. The national performance indicator for medical paediatrics shows an average of only 2% day cases (Department of Health 1990a). Most paediatricians greet this figure with incredulity, since they believe that their practice is dedicated to not admitting a child unless absolutely necessary. Perhaps the work being undertaken by the NHS Information Management Centre on ambulatory visit groups may help solve the situation for paediatrics. This term is likely to encompass out-patients, ward attenders and day cases and may take the emphasis away from administrative definitions.

DEFINING DAY ADMISSIONS

Because of continuing confusion over the definition of day cases and current efforts to widen the category to include all ambulatory patients (NHSME 1990) , we have paid little attention to definitions in this study. Instead we have concentrated on the child's experience of a short hospital visit.

1b. EXPLANATION OF TERMS USED IN THIS REPORT

CHILD

The term is used to cover the age range from 0 to 16 years inclusive. This complies with the latest guidance from the Department of Health and includes all children below the statutory minimum school leaving age. This does not preclude young people above the age of 16 continuing to use the children's services (Department of Health, to be published 1991).

PARENT

The person accompanying the child, who is called "parent" for short, could be one of a variety of people. An open mind and flexibility should prevail and the possibilities discussed with the family. It could simply mean the main carer, but the term might also cover grandparent, aunt, uncle, older sibling, nanny, au pair or close friend of the family.

DAY CASE

This includes patients admitted electively during the course of a day with the intention of receiving care or treatment which can be completed within a few hours so that they do not require to remain in hospital overnight, who return home as scheduled (DHSS 1987).

WARD ATTENDER

A patient who attends a ward for care but does not require the use of a hospital bed. Although not included in the bed statistics, ward attenders take up nursing time and should be recorded on the daily ward listing as part of the work of the ward (DHSS 1987).

AMBULATORY VISIT GROUP

This term has not yet been officially accepted, but it is possible that it will encompass outpatients, ward attenders and day cases, in a definition that concentrates on procedure rather than administrative aspects (NHSME 1990).

PLAY

The term "play" comprises a wide range of activities and covers every age group including adolescents. It can be divided into four types: diversionary or normal play; directed, acting out and developmental play to help children come to terms with their experiences of hospital; preparation and post-procedural play; and individual therapeutic play for children facing particular difficulties (Hogg 1990).

APPROPRIATELY TRAINED NURSE

For children this term means a registered sick children's nurse (RSCN) or one who has completed the child branch of Project 2000.

COMMUNITY PAEDIATRIC NURSE

Several different titles are used by districts, but we have decided on this one to describe a nurse trained in the care of sick children (see paragraph above) who carries out her duties mainly in the home.

PRIMARY AND/OR COMMUNITY SERVICES

With this phrase we refer to both the primary health care team and nurses working in the home.

Throughout this report "she" is used for a parent and "he" for a child, although we are aware that many fathers accompany their children to hospital and that girls make up a good proportion of patients. Similar decisions have been made for doctors and nurses. We ask readers to accept this system for the sake of convenience.

Part 2
Recommendations

In Part 2 we list our general recommendations, including 12 quality standards, for the provision and purchase of a day service for children. These are followed by the 42 principles for establishing such a service and the 21 principles for management of children in the theatre suite.

2a. GENERAL RECOMMENDATIONS

Purchasers and providers of day case services for children should adopt the following statement as their philosophy and as a basis for the development of policy.

Most children, when they are sick, are cared for by their families within their own homes, with the help of their general practitioners and community nurses. Children are more vulnerable emotionally than adults. They should be admitted to hospital only if the care they require cannot be provided equally well at home, since hospitalisation can be a distressing and difficult experience. An admission should always be child-centred, based on a partnership between the family and the health care team. Children should not be nursed alongside adults. When hospital care is necessary, children should not be admitted overnight if an equivalent level of care can be provided on a day basis. Such admissions involve parents in additional responsibilities and entail careful preparation and support of the family and efficient communication between the hospital and the primary and/or community services. The planning and delivery of care should recognise the multi-cultural nature and diverse needs of the population and make provision accordingly.

- Since day admission provides an equivalent and sometimes better level of care than an overnight stay, plans should be made for its expansion. Clinicians should examine their practices to see if they could expand day case services.

- Every effort should be made to gather children together into a children's day unit that admits both surgical and medical cases and also includes other ambulatory patients, such as ward attenders.

- If children have to be admitted to an inpatient children's ward for day treatment, a separate area, separate staff, separate policies and separate operational rules should be established in line with the twelve quality standards.

- If children have to be admitted to an adult/mixed day surgical unit for day treatment, separate sessions and/or separate facilities should be established in line with the twelve quality standards.

- To ensure that each day admission runs smoothly and calmly and is completed within the opening hours of the day programme, a specific set of policies, separate from inpatient policies, should be developed.

2b. 12 QUALITY STANDARDS

A PLANNED PACKAGE OF CARE FOR DAY CASE ADMISSIONS

Whenever and wherever a child (0-16 years) is admitted as a day case we suggest that the concept of a planned package of care is adopted. We recommend that such a package should contain the following standards, which might be used as quality standards in NHS contracts.

1. The admission is planned in an integrated way to include pre-admission, day of admission and post-admission care, and to incorporate the concept of a planned transfer of care to primary and/or community services.

2. The child and parent are offered preparation both before and during the day of admission.

3. Specific written information is provided to ensure that parents understand their responsibilities throughout the episode.

4. The child is admitted to an area designated for day cases and not mixed with acutely ill inpatients.

5. The child is neither admitted nor treated alongside adults.

6. The child is cared for by identified staff specifically designated to the day case area.

7. Medical, nursing and all other staff are trained for, and skilled in, work with children and their families, in addition to the expertise needed for day case work.

8. The organisation and delivery of patient care are planned specifically for day cases so that every child is likely to be discharged within the day.

9. The building, equipment and furnishings comply with safety standards for children.

10. The environment is homely and includes areas for play and other activities designed for children and young people.

11. Essential documentation, including communication with the primary and/or community services, is completed before each child goes home so that after-care and follow-up consultations are not delayed.

12. Once care has been transferred to the home, nursing support is provided, at a doctor's request, by nurses trained in the care of sick children.

2c. 42 PRINCIPLES UNDERLYING THE ESTABLISHMENT OF A CHILDREN'S DAY PROGRAMME

ENVIRONMENT

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

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

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

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

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

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

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

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

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

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

STAFF

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

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

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

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

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

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

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

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

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

ORGANISATION OF PATIENT CARE

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

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

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

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

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

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

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

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

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

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

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

28. Managerial and clinical audit should be a regular part of the organisation and delivery of patient care. Monitoring should also include the views of parents and older children.

DELIVERY OF PATIENT CARE

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

Outpatient and pre-admission period

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

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

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

On day of admission

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

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

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

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

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

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

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

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

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

Back at home

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

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

2d. 21 PRINCIPLES FOR THE MANAGEMENT OF CHILDREN DURING ANAESTHESIA, SURGERY AND RECOVERY

ENVIRONMENT

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

43. The areas of the theatre suite in which patients are conscious and can observe their surroundings should have decorations/pictures to attract and maintain a child's interest.

44. The anaesthetic and recovery rooms should have sufficient space to allow a parent to participate while the child is conscious.

45. In general hospitals with a centralised recovery room, one or more spaces should be allocated to children and be fully provided with equipment of an appropriate size for children of all ages.

46. In the recovery room arrangements should be made to separate children from adults as far as possible.

STAFF

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

47. Surgeons undertaking paediatric day surgery should have training in and experience of children's surgery. Day surgery should be undertaken only by consultants or surgical trainees under their supervision.

48. Anaesthetists undertaking paediatric surgery should have training in and experience of paediatric anaesthesia. Day surgery should be undertaken only by consultants or trainee anaesthetists under their supervision.

49. Theatre nurses and operating department assistants should be trained for and experienced in both day surgery and work with children and parents.

50. For the support of the parent there should be available a nurse or health care assistant accustomed to the routines of anaesthesia and recovery.

ORGANISATION OF PATIENT CARE

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

51. There should be close co-operation between the managers of the operating theatre department and the children's department to ensure that consideration is given to children's welfare in all managerial and organisational issues.

52. Agreed guidelines should be drawn up by all interested parties to help parents who enter the theatre suite.

53. When theatre lists are being prepared, the twelve quality standards for children's day admission should be kept in mind.

54. Clinical and managerial audit should be a regular part of the organisation and delivery of patient care for children in the theatre suite. Monitoring should also include the views of parents and older children.

DELIVERY OF PATIENT CARE

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

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

56. Every effort should be made to reduce the number of painful or frightening procedures while the child is conscious and to keep the admission as pleasant as possible.

57. A parent should be enabled to be with the child, to help with the care whenever the child is conscious and should be given timely information and support. The final decision to allow the parent to be present in the anaesthetic room should rest with the individual anaesthetist.

58. During the induction of anaesthesia safety issues must remain paramount and if a parent is present she should have been prepared for her role by the anaesthetist and/or day ward staff.

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

60. Consideration should be given by the surgeon to the use of appropriate means of simplifying post-operative care and ensuring the comfort of the patient.

61. For children there should be a one to one ratio of nurse to patient in the recovery area.

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

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

Part 3
For Purchasers

PHILOSOPHY, SPECIFICATIONS AND MONITORING

PHILOSOPHY

The following statement relates day case admissions to the overall system of care for sick children. The CCHS Committee recommends that health authorities adopt it as their philosophy and as a basis for the development of policy.

Most children, when they are sick, are cared for by their families within their own homes, with the help of their general practitioners and community nurses. Children are more vulnerable emotionally than adults. They should be admitted to hospital only if the care they require cannot be provided equally well at home, since hospitalisation can be a distressing and difficult experience. An admission should always be child-centred, based on a partnership between the family and the health care team. Children should not be nursed alongside adults. When hospital care is necessary, children should not be admitted overnight if an equivalent level of care can be provided on a day basis. Such admissions involve parents in additional responsibilities and entail careful preparation and support of the family and efficient communication between the hospital and the primary and/or community services. The planning and delivery of care should recognise the multi-cultural nature and diverse needs of the population and make provision accordingly.

SPECIFICATIONS

When estimating the need for day admissions, authorities will have to take into account the clinical and social limitations (Part 4a) and the facilities currently available in provider hospitals (Part 4b).

Current day case programmes for children vary enormously in quality and extent. They demonstrate a lack of vision and an absence of objectives, policies and operational guidelines. With this in mind we present 6 general recommendations and twelve quality standards in Parts 2a and 2b. If the latter are included in a NHS contract as quality measures we believe they will result in a service of acceptable quality. They are all attainable in an "average" district general hospital and, in other parts of this report, advice is given for provider units on the various ways they could be achieved.

MONITORING

Purchasers will need to monitor providers' compliance with the standards they require. To this end it would be helpful if contracts for day case services allowed data to be identified in such a manner that:

- children could be audited separately
- day patients could be separated from inpatient admissions
- rates of transfer to inpatient care and readmission could be reviewed
- integration of hospital and community care could be monitored
- the child's and parent's opinions of the service could be obtained.

A checklist for monitoring the twelve quality standards (see part 2b) appears on the following page.

CHECKLIST BASED ON THE TWELVE QUALITY STANDARDS

1. Are the three stages of provision planned in an integrated manner: pre-admission, preparation and assessment; day of admission including handover to the general practitioner; aftercare at home?

2. Is preparation offered to both child and parent both before and during the day of admission?

3. Does the written information for parents clearly outline their responsibilities prior to and following the admission and opportunities for their participation on the day; and is it written in a way that all parents can understand?

4. Is there a specific area designated for day patients separate from that for inpatients who are acutely ill?

5. Are children treated and nursed separately from adults?

6. Are identified staff specifically designated to the day case area?

7. Are medical, nursing and other staff trained for, and skilled in, the care of children and their families?

8. Are the organisation and delivery of patient care planned specifically for day patients so that every child is likely to be discharged within the day.?

9. Do the building, equipment and furnishings comply with safety standards for children?

10. Is the environment homely and does it include areas for play and other activities for children and young people?

11. Is essential documentation, including communication with the primary and/or community services, completed before the child goes home?

12. Are nurses, trained in the care of sick children, available to provide support in the home?

Part 4
For Providers

4a. THE SCOPE OF DAY CASE MANAGEMENT FOR CHILDREN

This Part is divided into two. First the procedures suitable for day treatment are discussed, for both surgery and medicine. The second section covers the selection of patients suitable for day treatment looking at clinical and non-clinical criteria.

SELECTION OF PROCEDURES SUITABLE FOR DAY TREATMENT

Surgical

Day cases are elective and existing statistics suggest that for children most are surgical. In 1985 the Royal College of Surgeons of England produced encouragement and advice for day surgery prepared by a special commission (RCS 1985). These guidelines contain a section on paediatric surgery and specific references to children in other surgical specialties. The guidance and procedures mentioned in the guidelines have been used as a basis for the following principles and lists. They have been extended by discussion with professional organisations.

The choice of suitable operations is likely to be limited by the following major principles:

- Ideally the anaesthetic and operating time should not exceed 40 minutes to one hour. Clearly many of the procedures will be much shorter.
- Procedures should be chosen which have a low incidence of post-operative complications.
- The management of the patient after returning home, including pain relief and dressings, should be feasible for parents, possibly with the help of community nurses.

The following operations fit these criteria and are undertaken as day surgery in many hospitals at the moment.

General surgery/Urology
Inguinal hernia
Umbilical hernia
Epigastric hernia
Ligation of communicating hydrocele
Orchidopexy
Circumcision
Meatotomy
Minor revision of hypospadias
Separation of preputial adhesions
Division of tongue tie
Cystoscopy
Proctoscopy
Sigmoidoscopy
Anal sphincter stretch
Examination under anaesthesia
Manual evacuation of faeces
Excision of local skin lesions & cysts
Gastroscopy
Oesophagoscopy

Orthopaedic surgery
Manipulations
Change of plaster
Removal of pins, plates and screws
Trigger thumb, ganglia & similar minor procedures
Arthroscopy

Dental surgery
Conservation
Extraction

ENT surgery
Minor aural surgery e.g. diagnostic examination under anaesthesia, suction clearance including removal of foreign bodies, myringotomy and insertion of grommets, electrocochleography, fat graft myringoplasty, aural polypectomy, change of mastoid dressing.

Minor nasal surgery e.g. diagnostic examination under anaesthesia, endoscopy, fracture of the nasal bones, cautery, submucous diathermy, removal of foreign

body, polypectomy, biopsy, dilation of choanae, antral washouts, drainage of septal haematoma.

Minor oral/pharyngeal/laryngeal surgery e.g. release of tongue tie, endoscopy, some laser treatments. For tonsillectomy and adenoidectomy see paragraph on future developments (below).

Ophthalmic surgery
Tear duct probing
Strabismus surgery
Examination under anaesthesia
Excision of chalazion and other benign lid lesions

Plastic and dermatological surgery
Accessory auricles and digits
Incomplete, simple syndactyly
Correction of prominent ears
Dermoid cysts
Minor revisions of nose and lip following treatment of cleft lip and palate Meatotomy, circumcision and "tidy-up" procedures after repair of hypospadias
Excision and revision of various hamartomata
Pulsed dye laser treatment of portwine stain birthmarks

Gynaecological surgery
Termination of pregnancy

Future developments
This list is not static and no doubt will be altered with further experience and developments. For instance in some centres advances in day treatment have led to conditions such as a thyroglossal cyst, branchial sinuses, and the repair of minor variants of hypospadias to be performed on a day basis.

The British Association of Otolaryngologists has reservations concerning day case adenoidectomies and adenotonsillectomies and the Council is currently studying the problem. Haemorrhage is the commonest complication. A study at the Royal National Throat Nose and Ear Hospital of 20,671 children, showed that 0.47% of the adenoidectomies and 0.44% of the tonsillectomies bled. This occurred most frequently within 12 hours of operation and no reason for the bleeding in these particular patients could be found (Capper and Randall 1984). Factors others than the likely incidence of post-operative haemorrhage are considered in Shott, Meyer and Cotton (1987).

Medical

For medical paediatrics, the situation is less clear. The governing and training bodies have produced no guidance on day case management, though there is widespread and general expectation that paediatricians will keep admissions short and consider the needs of families. The statistics are not helpful. The 1987 Performance Indicator package shows that the national average of day cases for medical paediatrics is only 2% (Department of Health 1990a). There is a generally held view that many cases are being wrongly recorded and one of the previous research studies of this Committee upheld this suggestion (Thornes 1988). However, since at least 90% of paediatric medical admissions are non-elective (Hill 1989) and much of the follow-up care can be done on an outpatient or ward attender basis, there is possibly less opportunity for an increase in day treatment. Evidence has been taken from all the paediatric medical sub-specialties and a list of procedures built up. The following principles are for general guidance:

- A child should be kept in hospital after tests or procedures only if there are exceptional reasons.
- Procedures should be carefully planned to minimise the waiting time, on an individual basis.
- The management of the patient after returning home should be feasible for parents, supported by the knowledge of whom to contact for help.
- When a general anaesthetic is used the procedure time should not exceed 40 minutes to one hour. Clearly many of the procedures will be much shorter.

The following planned procedures are undertaken on a day basis in many districts:

Investigations
For example: tolerance tests, jejunal biopsy, bone marrow aspirations, lumbar punctures, endoscopy, CT scan or other radiological procedures requiring anaesthesia or sedation.

Therapy
For example: establishment of intravenous treatment for children with cystic fibrosis, administration of immunoglobulin, blood transfusion, chemotherapy. Other examples include haemodialysis and enemas given for encopresis.

Multi-purpose
For example: to undertake measurements, baseline investigations and discussion with parents, for instance for children with renal problems or newly diagnosed diabetes.

SELECTION OF PATIENTS SUITABLE FOR DAY TREATMENT

Clinical principles

- Children who are to have a general anaesthetic should be fit, normally falling into ASA Classes 1 or 2 (see Appendix I).

  ASA Class 1: The patient has no organic, physiological, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localised and does not entail a systemic disturbance.

  ASA Class 2: Mild to moderate systemic disturbance caused by either the condition to be treated surgically or by other pathophysiological processes.

- When a general anaesthetic is necessary, children and infants of all ages are suitable. The exception is the premature baby who has not reached 44 weeks post-conceptual age (Gregory and Steward 1983). Special consideration should be given to babies who have been on ventilatory support.

Non-clinical principles

- The parent must be able to cope with pre-procedure instructions and with the care of the child after treatment.

- The parent must agree to day treatment, following adequate information and an opportunity to discuss any anxieties.

- The parent must be available to stay throughout the day, though there may be exceptions for older children who attend regularly.

- The parent must be able to make arrangements for the practical care of the child for a named period of time following transfer of care to home.

- Facilities in the home should be taken into account.

- Travel conditions and journey time should be taken into consideration. After a general anaesthetic the use of public transport is inappropriate and the hospital must take responsibility for checking that suitable transport is available (DHSS 1973).

- Children with a long term serious illness, disability or handicap whose parents are carrying out day to day care at home, should be treated on a day basis when hospitalisation is required, whenever this is appropriate and would be beneficial to the child and family.