# Day Case First: National Day Surgery Delivery Pack

## Appendices

**September 2024, Version 2.0**

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# Introduction

A key element of the GIRFT ethos is to identify and share best practice and resources between trusts, highlighting approaches and processes which can improve care and patient outcomes, as well as deliver efficiencies. This appendix includes a number of example documents and approaches that may be useful for those involved in the delivery of day case surgery. Services may want to adapt the following templates and proformas to suit local circumstances. It should be noted that these documents are examples of good practice and that other approaches may also be appropriate.

# Section 1

## Template Documents: example letters from preoperative assessment

**Examples from Torbay and South Devon, 2023**

**Template: Newly detected Atrial fibrillation**

Private & Confidential

To: GP

Your patient [insert name] attended the preoperative assessment clinic today. Routine ECG showed her to be in atrial fibrillation, I enclose a copy. We have no record of this patient previously being in atrial fibrillation and thought it may be useful for you to be aware of this.

Yours sincerely,

[Insert name of service and provider]

**Template: Poorly controlled hypertension**

The above patient came into the Day Surgery Unit today for preoperative assessment for surgery.

We have taken a blood pressure reading and this is showing:

Systolic: Time:

Diastolic: Time:

I would be grateful if you would see this patient and assess whether or not they would benefit from anti-hypertensive treatment.

The patient has been asked to make an appointment to see you in the near future.

Yours sincerely,

[Insert name of service and provider]

**Template: Abnormalities of blood results**

The above patient came into the Day Surgery Unit for preoperative assessment and had some investigations performed.

[Insert patient name] results (attached) have shown some abnormality and although this does not preclude [insert patient name] from surgery, I am bringing this to your attention for further action if you think it necessary.

Yours sincerely,

[Insert name of service and provider]

**Template: Poorly controlled diabetes (patient letter – urgent surgery)**

I'm writing to you because you recently attended a preoperative assessment appointment at the Day Surgery Unit in preparation for your [insert procedure] operation.

As part of this assessment we checked a blood test which measures how well controlled your diabetes is. This blood test is called HbA1c and your value came back as [insert value] mmol/mol. This indicates that your diabetes is not very well controlled at the moment. Because the surgeon [insert name] needs to go ahead with your operation fairly urgently we will not be delaying your operation, however if you were to need surgery in the future which was not urgent, we would not be able to proceed with this until your diabetes is under better control.

I have today written to your GP and asked that they work with you to improve the control of your diabetes both for your long term health, but also to ensure that any future surgery is able to proceed without delay.

If you have any questions regarding this please do contact your GP for further advice.

Yours sincerely,

[Insert name of service and provider]

**Template: Poorly controlled diabetes (patient letter – routine surgery)**

I am writing to you because at your recent preoperative assessment appointment we took the opportunity to check how well controlled your diabetes is. Unfortunately your HbA1c (a blood test which measures your long term blood sugar control), was found to be very high and is currently at [insert value] mmols/ml

I have sent a letter to your Surgeon, your GP and our specialist diabetes team. I have asked the healthcare professionals who are responsible for your diabetes care (usually your GP or in some cases our hospital-based specialist diabetes team) to work with you to help support you in improving your blood sugars. Because of this, your Surgeon may decide that your operation needs to be delayed until your blood sugars are better controlled. This is because there are more complications after surgery in those patients who have high blood sugars. The recommended target HbA1c to safely proceed with non-urgent surgery is less than 69mmols/mol.

Please do not hesitate to contact us if you have any concerns regarding this and we very much hope that you will be able to work with your diabetes care providers to help improve your blood sugar levels before surgery. This is important to reduce the risk of surgical complications and improve the outcome following your surgery. It will also reduce your risk of subsequent complications resulting from your diabetes.

Yours sincerely,

[Insert name of service and provider]

**Template: Poorly controlled diabetes (letter to surgeon and GP)**

Your patient [insert name] attended the preoperative assessment clinic this week prior to their elective surgery. [Insert name] is known to suffer from diabetes and unfortunately at the time of their pre-operative assessment their HbA1c was found to be high.

[Insert name] current HbA1c is mmols/mol.

Local and national guidelines recommend that glucose control should be optimized aiming for a HbA1c of less than 69mmols/mol prior to surgery, where it is appropriate to do so safely. This is because of significant increase in perioperative mortality and morbidity including the increased risk of infection, in undertaking surgery in patients with persistently elevated blood glucose levels.

I am copying this letter to your patient's GP, to ask that they work with them to try to improve their control. I have also alerted our specialist diabetic team who are happy to be contacted to provide additional support should the primary care team require advice about how best to optimise diabetic management of this patient.

Please would you review whether this surgery needs to proceed as planned or whether it can be deferred until such time that the GP or diabetic team confirm that their diabetic control has been optimised.

I have written to [insert name] to inform them that their surgery may be delayed and encourage them to engage with the relevant healthcare professionals in order to improve their diabetic control.

Please don't hesitate to contact me if you have any questions regarding this.

Yours sincerely,

[Insert name of service and provider]

Affix Patient Label

**Patient Post Operative Self - Medication Chart**
**Torbay Day Case Primary Hip Arthroplasty**

Torbay and South Devon NHS
NHS Foundation Trust

## Record of doses taken - Patient to tick each time dose taken

*Discharging nurse to please write days of week in table below*

***Initial discharge chart** – see next page for day 3 onwards……*

| | *Day of week /dates:* | | | | |
|---|---|---|---|---|---|
| | | **Day of Operation** | **Day 1** | **Day 2** | **Notes:** |
| **08.00** | Paracetamol * | Any required doses of these will have been given to you during your time in hospital | | | |
| | Omeprazole | | | | Only if on Ibuprofen |
| | Oxycodone | | | | Stop medicine |
| | Macrogols | | | | |
| | Pregabalin | | | | |
| | Ondansetron | | | | Stop medicine |
| | Aspirin | | | | |
| **14.00** | Paracetamol * | | | | |
| | Ondansetron | | | | Stop medicine |
| **18.00** | Paracetamol * | | | | |
| | Oxycodone | | | | Stop medicine |
| | Macrogols | | | | |
| | Pregabalin | | | | |
| **22.00** | Paracetamol* | | | | |
| | Ondansetron | | | | Stop medicine |

**Is the patient usually on tablets for high blood pressure?**
☐ **Yes** ☐ **No**
**If yes please complete additional sheet (p4)**

## NOTES

**If** you have also been prescribed **Ibuprofen** as part of your take home medication please take a dose each time you take the Paracetamol* dose – up to a maximum of 4 times per day. You will also have been given a 5 day course of Omeprazole if we send you home with Ibruprofen. Please take this as indicated on the chart. If you have not been sent home with Ibuprofen by us you do not require the Omeprazole.
Further notes on page 2.

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# Torbay Day Case Primary Hip Arthroplasty
## Patient Post Operative Self-Medication Chart



| ***Day of week / dates:*** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | **Day 3** | **Day 4** | **Day 5** | **Day 6** | **Day 7** | **Day 8** | **Day 9** | **Day 10** | |
| **08.00** | Paracetamol * | | | | Stop medicine if you can – if not then OK to continue as you need | | | | | |
| | Omeprazole | | | | Stop medicine – unless you are on this normally | | | | | |
| | Codeine OR Tramadol | | | | Stop medicine | | | | | |
| | Macrogols | | | | Stop medicine | | | | | |
| | Pregabalin | | | | | | | | | Continue until Day 14 |
| | Aspirin | | | | | | | | | Continue until Day 28 |
| | | | | | | | | | | |
| **14.00** | Paracetamol * | | | | Stop medicine if you can – if not then OK to continue as you need | | | | | |
| | Codeine OR Tramadol | | | | Stop medicine | | | | | |
| | | | | | | | | | | |
| **18.00** | Paracetamol * | | | | Stop medicine if you can – if not then OK to continue as you need | | | | | |
| | Codeine OR Tramadol | | | | Stop medicine | | | | | |
| | Macrogols | | | | Stop medicine | | | | | |
| | Pregabalin | | | | | | | | | Continue until Day 14 |
| | | | | | | | | | | |
| **22.00** | Paracetamol * | | | | Stop medicine if you can – if not then OK to continue as you need | | | | | |
| | Codeine OR Tramadol | | | | Stop medicine | | | | | |

**NOTES… continued from page 1**

Your Oxycodone is prescribed for the first two days **only** – this medication can be very addictive and **must not** be continued longer than this period. Please do not approach your GP to ask for it to be continued – they have been asked by us not to reissue it.

At Day 3 you should take the Codeine (or Tramadol) that you have been sent home with instead. Do not take the Codeine (or Tramadol) whilst you are still taking the Oxycodone.

| Drug Name | How many **times a day** do I take this ? | How many days do I take this **for ?** | **What is it for ?** | **Additional Information** |
|---|---|---|---|---|
| **Paracetamol** | 4 | 5 days | Pain relief | This is an excellent 'foundation' pain reliever which will improve the effect of your other pain medicines. |
| **Ibuprofen** | 4 | 5 days | Pain relief | Some people can't take Ibuprofen. Your anaesthetist will have made a decision if this is an appropriate medicine for you and IF appropriate you will have been discharged with it. If it has been provided take it each time you have your Paracetamol dose. |
| **Omeprazole** | 1 | 5 days | Stomach protection | If you have been sent home with Ibuprofen this medicine will help protect your stomach lining whilst you are on the Ibuprofen. |
| **Oxycodone SR** | 2 | **First 2 days only** | VERY STRONG pain relief | This will be 'stepped down' after the first two days to a different pain medicine: either Codeine or Tramadol will have been prescribed for you. **IMPORTANT: DO NOT TAKE CODEINE OR TRAMADOL WHILST ON THIS MEDICINE**. |
| **Codeine Phosphate OR Tramadol** | 4 | Days **3 – 5 only** | STRONG pain relief | ONE of these two will have been prescribed as your 'step-down' pain medicine when your very strong Oxycodone medicine ends. Your anaesthetist will have decided which one is the most appropriate for you. **IMPORTANT: DO NOT TAKE WITH OXYCODONE M EDICINE.** |
| **Pregabalin** | 2 | 14 days | Pain relief – has direct nerve action | This pain medicine acts in different ways to other pain relief medicines and you should take it for 14 days after your operation, then it should be stopped. |
| **Ondansetron** | 3 | 2 days | To reduce/ prevent nausea ('feeling sick') | You should only need this as a precaution whilst you are on the strong pain-reliever Oxycodone. |
| **Macrogols** | 2 | 5 days | To reduce/ prevent constipation | Strong pain medicines will often cause constipation. We don't want this to happen for you so we are sending you home with medicine to prevent this |
| **Aspirin 150mg** | 1 | 28 days | To reduce risk of a blood clot (DVT) | We need you to take aspirin to reduce the chance of you getting a blood clot in the veins of the leg (DVT). If you are already on other 'blood thinning' drugs e.g. Warfarin or Clopidogrel your post op plan will be different and you will not be issued with this 28 day course of Aspirin. |

**Torbay Day Case Primary Hip Arthroplasty**
**Additional Sheet:**



**Required for patients who normally take tablets for High Blood Pressure**

After your operation you blood pressure can sometimes be lower than normal – this is quite common.

If you are normally taking medicines for high blood pressure then we need to review what is happening with your blood pressure after the operation before these tablets are re-started to make sure it is safe.

Please do **NOT** take the following medication in the days after your operation until advised to restart*:

…………………………………………………………………………………………………

…………………………………………………………………………………………………

…………………………………………………………………………………………………

Your outreach nurse will review these and your blood pressure when they see you and will tell you when you can re-start your medicines.

Please show them this sheet when they come and visit you.

Please take all your other medicines as normal unless explicitly told not to by one of the doctors or nurses looking after you.

* Instructions for discharging nurse:

Please review patients 'blue top' preassessment PICIS – details in addenda will have been left by a pre- op anaesthetist stating what medications need to be held post op for this patient.

Please copy these instructions onto this paper for the patient to take home with them.

The outreach nurse/GP will restart when appropriate post op. Dr Hinde can be approached to assist with any medication related queries in this regard

Beta blockers should not be stopped nor should drugs which are for arrhythmias but medication for high blood pressure e.g. ACE inhibitors (Ramipril etc) should be held.

# Day Surgery Unit - Perioperative Prescription Chart

Patient Name

Hospital Number

Date of Birth

**Drug Allergies**

**Preoperative Medication**

| | | Time given |
|---|---|---|
| Paracetamol | Yes/No | |
| Ibuprofen | Yes/No | |

| Drug | Dose | Route | Frequency | Time | Signature | Time | Signature |
|---|---|---|---|---|---|---|---|
| Paracetamol | 1g | po/iv | 4 hourly | | | | |
| Ibuprofen | 600mg | po | 4-6 hourly | | | | |
| Morphine Sulphate (Oramorph) | 10mg | po | 2 hourly | | | | |
| Morphine Sulphate (Oramorph) | 20mg | po | 2 hourly | | | | |
| Metoclopramide | 10mg | po/iv | 8 hourly | | | | |
| Ondansetron | 4mg | iv | 8 hourly | | | | |
| Cyclizine | 50mg | iv | 8 hourly | | | | |
| fentanyl | 25mcg | iv | 1st Dose | | | | |
| *(max 6 doses then review)* | | | 2nd Dose | | | | |
| | | | 3rd Dose | | | | |
| | | | 4th Dose | | | | |
| | | | 5th Dose | | | | |
| | | | 6th Dose | | | | |
| Others (list below) | | | | | | | |
| | | | | | | | |
| Hartmanns | 500mls | iv | | | | | |

I authorise all the above post operative medications according to unit protocols

**Doctors Signature** **Date**

## Day Surgery Unit- Paediatric Perioperative Prescription Chart

**Patient name**

**Hospital number**

**Date of birth**

**Drug Allergies**

| **Preoperative Medications** | | Time |
|---|---|---|
| Paracetamol | Y/N | |
| Ibuprofen | Y/N | |
| | | |

**WEIGHT________________Kg**

| Drug | Dose | Route | Frequency | Time | Signature | Time | Signature |
|---|---|---|---|---|---|---|---|
| **Paracetamol** 15mg/kg | | po/iv | 4-6 hourly | | | | |
| **Ibuprofen** 5mg/kg | | po | 4-6 hourly | | | | |
| **Oramorph 1-2 yr** 0.2-0.4 mg/kg | | po | 4 hourly | | | | |
| **Oramorph 2-12 yr** 0.2-0.5 mg/kg (Max dose15mg) | | po | 4 hourly | | | | |
| **Oramorph 12-15 yr** 5-15mg | | po | 4 hourly | | | | |
| **Oramorph 16-18 yr** 10-20mg | | po | 2-4 hourly | | | | |
| **Ondansetron** 0.1mg/kg (Max 4mg) | | po | 8 hourly | | | | |
| **Fentanyl** 0.3mcg/kg | | iv | 1st Dose | | | | |
| | | iv | 2nd Dose | | | | |
| **Others** (list below) | | | | | | | |
| | | | | | | | |
| | | | | | | | |

I authorise all the above post operative medications according to unit protocols

**Doctors signature** **Date**

## Acute Pain Protocol For Adult Surgery

| | Pain Intensity | Discharge Medication | Doctors Signature (sign one box only) |
|---|---|---|---|
| A | None | None | |
| B | Mild | Paracetamol 1g QDS | |
| C | Moderate | Paracetamol 1g QDS<br>Plus<br>Ibuprofen 600mg QDS | |
| C* | Moderate (NSAID intolerant) | Paracetamol 500mg/Codeine 30mg i-ii QDS<br>Laxido 1 Sachet BD | |
| D | Severe | Paracetamol 500mg/Codeine 30mg i-ii QDS<br>Plus<br>Ibuprofen 600mg QDS<br>Plus<br>Laxido 1 Sachet BD | |
| D* | Severe (NSAID intolerant) | Paracetamol 1g QDS<br>Oromorph 20mg QDS | |

### PAIN CATEGORIES FOR COMMON PROCEDURES IN THE DAY SURGERY UNIT

| A | B | C | D |
|---|---|---|---|
| EUA Ears<br>Cystoscopy<br>Restorative Dentistry | Cataract Surgery<br>Grommets or T tube removal/insertion<br>Prostate Biopsy<br>Sebaceous Cyst Surgery<br>Sigmoidoscopy<br>Skin Lesion Surgery<br>Urethral Surgery | Anal Surgery<br>Apicectomy<br>Arthroscopy<br>Axillary Clearance<br>Breast Lumps<br>Dupuytren's contracture<br>Carpal Tunnel Decompression<br>Cervical/vulval Surgery<br>Hysteroscopy/D&C<br>Middle Ear Surgery<br>MUA +/- Steroid Injection<br>Vaginal Sling<br>Varicose Vein Surgery<br>Vasectomy<br>Non-Wisdom Tooth Extraction | ACL Reconstruction<br>Circumcision<br>Endometrial Ablation<br>Laparoscopy<br>Haemorrhoidectomy<br>Hernia Repair<br>Joint Fusions & Osteotomies<br>Shoulder Surgery<br>Squint Surgery<br>Testicular Surgery<br>Tonsillectomy<br>Wisdom Tooth Extraction<br>Dental Clearance |

## Day Surgery Care Planning Summary Letter

Torbay and South Devon NHS
NHS Foundation Trust

*Day Surgery Unit*
*Torbay Hospital*
*Lowes Bridge*
*Torquay*
*TQ2*
*7AA*
*Tel: (01803) 655508*
Date: 02/09/2019

**DAY SURGERY CARE PLANNING SUMMARY**

**Hospital Number:**

**Patient Name/DOB/Address**:

**Date of Admission:**

**Consultant:**

**Operating Surgeon: Sub specialty:**

***Operation Details:***
**Operation Performed:**
**Operation Date:**

**Medication Information:**

**Sutures out:**

**Follow-Up Outpatient appointment required:**

**Dressing/Wound check:**
**Additional discharge information:**

Between the hours of 8am – 8pm (Monday – Friday) expert advice should be sought from the Day surgery Unit on 01803 654055

If urgent advice is required overnight, your patient and carer have been told that they may contact the hospital switchboard on 01803 614567 and ask for the surgical nurse bleep holder, (bleep 110), for help. The call will be dealt with by an experienced nurse who will seek medical advice if this is judged to be necessary.

A nurse from the Unit will telephone you tomorrow to confirm that all is well. **Further expert advice should be obtained from your GP if required**.

Derby Hospitals

NHS

NHS Foundation Trust

## Procedure Targeted Spinal Anaesthesia Prilotekal or Ampres

Saddle Block?

YES → Prilotekal 0.5-1ml

**PERINEAL SURGERY**

Haemorrhoids, fissure, fistula, abscess, EUA

Perianal abscess

Circumcision/Meatoplasty

Vulval surgery

NO ↓

>T10 block?

YES → Prilotekal 3+ml

**GENERAL** Epigastric/Umbilical hernia

**GYNAE** Diagnostic laparoscopy

**UROLOGY** Ureteroscopy+/-stent and laser

NO ↓

>1 hour?

YES → Prilotekal 2-3ml

**GENERAL** Inguinal /femoral hernia

Recurrent or Bilateral Hernia

Bilateral VVs

**ORTHO** ACL/MPFL

**GYNAE** Vaginal repair

Colposuspension/colpocleisis

+/- vag hyst

**UROLOGY** TURP

NO ↓

Ampres 4-5 ml

**GENERAL** Single VVs/RF Veins, Lumps/Bumps, Inguinal Hernia

**ORTHO** Knee Arthroscopy(incl Bilat) Foot and ankle

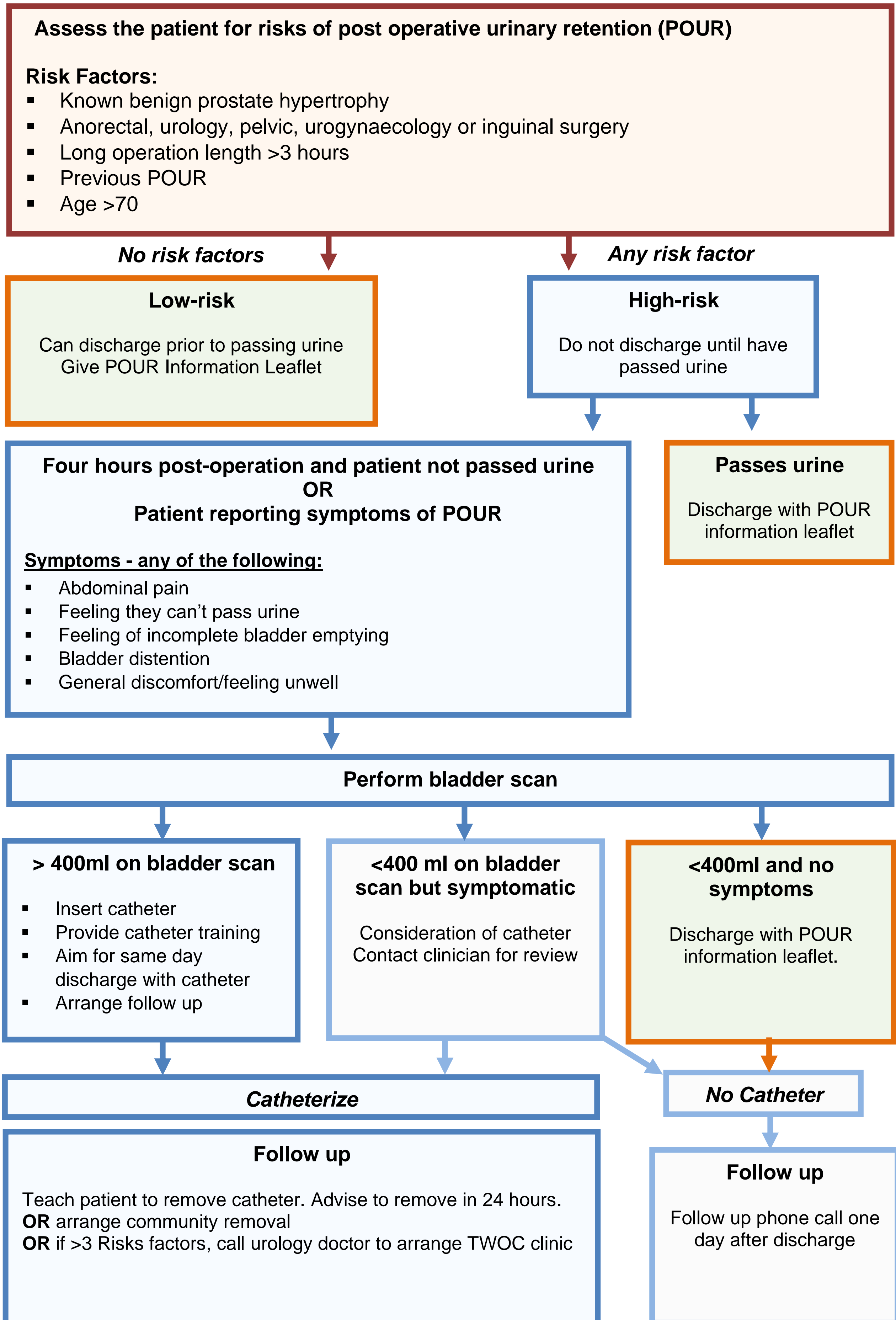
**GYNAE** Hysteroscopy D&C, TVTminor repair

**UROLOGY** BNI, cysto/diathermy. Check cysto.

Robbie Erskine June 2024

## Bladder Management Flowchart

**Authors, Kayleigh Spellar, David Bunting on behalf of the British Association of Day Surgery, April 2024.**



## Vignette: Productivity and Patient Outcomes[1 2]

**Torbay and South Devon NHS Foundation Trust**

Data shows that managing day surgery activity through a dedicated unit results in increased productivity and improved outcomes in terms of unplanned admission rates and postoperative symptoms.

**Productivity:**

- 33% increase in productivity for hernia repairs if undertaken within the day surgery unit rather than inpatient theatres.
- 47% increase in productivity in moving the hand surgery list from inpatient theatres to the day surgery unit.
- 2-hour increase in the total pathway time for a day surgery patient if they are managed through the inpatient theatre suite. This results in inefficiencies for the trust and a poorer experience for patients.

**Patient Outcomes:**

There have been three attempts to open a satellite day surgery ward adjacent to the inpatient theatre suite to accommodate day surgery activity being undertaken via the inpatient theatres (largely due to insufficient capacity in DSU).

- 2003-5 Orthopaedic day beds on an elective orthopaedic ward
- 2008 Generic day surgery secondary recovery on an orthopaedic ward
- 2010 Generic day surgery secondary recovery on a previously closed surgical ward

On all three occasions patient outcomes were poorer with higher pain scores and unplanned admission rates being between 3 to 10-fold higher than for matched patients operated upon within the dedicated day surgery unit.

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[1] Day Surgery in different guises – a comparison of outcomes. (2009) Journal of One-Day Surgery, 19: 39-47.
[2] Warren, G., Carter, J., Humphreys, A., and Stocker, M.(2020) The benefits of a Dedicated Day Surgery Unit, Journal of One Day Surgery 30.2.

## Post-Op Phone Call Proforma - Torbay

| General Feeling | Satisfaction | Pain Score | Nausea | Vomiting | Dizziness | Drowsiness | Did You like being a Day Case | Did You Like Our Unit | Comments |
|---|---|---|---|---|---|---|---|---|---|
| Very Good | Very Satisfied | None | None | None | None | None | Yes | Yes | |
| Good | Satisfied | Mild | Mild | Once | Mild | Mild | No | No | |
| Reasonable | Not Satisfied | Moderate | Moderate | 2 or more times | Moderate | Moderate | | | |
| Bad | | Severe | Severe | | Severe | Severe | | | |
| | | | | | | | | | |

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## Torbay Day case Hip / Uni-knee Replacement Anaesthetic Protocol

### Pre-Op

- Carbohydrate drink 2hrs pre op. **Patient should be 1st on theatre list.**
- Withhold ACEi/A2RB medication on day before AND day of surgery
- Ensure patients are not cold – prewarm

**Pre-meds:**

- Paracetamol 1g
- Ibuprofen 1600mg SR if no contraindication
- **Oxycodone MR 10mg** (*5mg if age >70)

### Intra-Op

| HIP | KNEE |
|---|---|
| ☑ Spinal +<br>☑ Surgical Infiltration | ☑ Spinal +<br>☑ Saphenous block (US guided) +<br>☑ Surgical Local Infiltration |

**Spinal:**

- 3 - 3.4mls hyperbaric 2% Prilocaine– (Day cases)
- *NO INTRATHECAL OPIOID*
- +/- small boluses of IV fentanyl during skin closure if needed.

Insertion → SUPINE 2 mins → Then <30° head up

**Local Anaesthesia**

- HIPS: Surgical infiltration 0.25% levobupivacaine 50mls (40mls if <60kg)
- KNEES: Ultrasound guided saphenous block + Surgical infiltration (ensure maximal LA dose not exceeded with combined technique)

**Antiemetics:**

- Dexamethasone 6.6mg IV at start **AND**
- Ondansetron 4mg IV towards end

*BOTH ARE NEEDED – PONV a significant issue*

**Other:**

- Goal: **Minimise sedation** (if req – low dose TCI propofol)
- Goal: **Normothermia** – proactively warm patient
- Goal: **Normovolaemia** – warmed IV fluids 1000-2000mls
- Goal: **Blood conservation** – Tranexamic Acid **1g IV at start of case + further 1g IV dose at end of case** + use of **Cell Salvage ROUTINELY** collection
  - NB: Tranexamic acid use 10mg/kg if eGFR <50 and/ or weight <50kg
- Antibiotic administration & appropriate mechanical thromboprophylaxis

<table>
<tr><td rowspan="2">Post Op</td><td><u>Recovery:</u><ul><li>Additional antiemetic if needed</li><li>Oral fluids to commence</li><li>Build up/ Fortisip drink (unless diabetic) – please prescribe for PACU</li><li>Fragmin 5000units sc pre discharge</li></ul></td><td>If not PU'd then pt needs catheterising pre discharge- please inform Ortho Outreach Tel: 01803 654718</td></tr>
<tr><td colspan="2"><u>TTAs:</u><ul><li>Paracetamol 1g po qds 5/7</li><li>Ibuprofen 400mg-600mg po qds 5/7 (if no contraindication) + PPI cover (Omeprazole 20mg)</li><li>Oxycodone MR 10mg po bd for 4 post op doses (*5mg if age >70) with reinforced non continuation of this via discharge summary (automated process)</li><li><u>THEN step down to:</u> Codeine 30-60mg po qds OR Tramadol 50-100mg qds if codeine intolerant for 3/7.</li><li>Ondansetron 4mg po tds for 2/7</li><li>Macrogols 1 sachet po bd 5/7</li><li>Aspirin 150mg po od 28/7 - unless other anticoag plan in place e.g. warfarin/clopidogrel</li></ul></td></tr>
</table>

# Torbay Day Case Primary Hip Arthroplasty Pathway

| | |
|---|---|
| PATIENT IDENTIFICATION | • Patient listed for simple primary total hip replacement via MSK pathway<br>• Opportunities for identification as day case candidate: preassessment, consent clinic<br>• Patient attends joint school, day case may be mentioned<br>• Identify anaesthetist for list and inform them of day case |
| PREOPERATIVE | • Straightforward surgery expected<br>• Age <70<br>• BMI <30<br>• ASA 1 or 2<br>• No complex pain issues, must not be on opioids already<br>• No respiratory or unstable cardiac disease<br>• Motivated with robust home set up, meets standard day case criteria<br>• Screen for nocturia/prostatic symptoms (not prohibitive but inform team) |
| INTRAOPERATIVE | • First patient on the list<br>• Enhanced recovery: carbohydrate drinks, free clear fluids until sent for, keep warm<br>• Premedicate with pregabalin, oxycodone SR, paracetamol and ibuprofen<br>• Prilocaine spinal, minimal sedation<br>• Antibiotics, tranexamic acid, balanced fluids, aim 1000ml but consider blood loss<br>• Surgeon to infiltrate skin during cementing and infiltrate joint with LA<br>• Complete day case PACU meds and TTOs to include controlled drug prescription for oxycodone, dalteparin to be given at 1400 |
| PRIMARY RECOVERY | • Alert DSU that patient is in primary recovery<br>• Preliminary observations and discharge to secondary recovery after standard criteria are met |

| SECONDARY RECOVERY | • Ensure observations stable and BP within 20% baseline for $\geq$ 1 hour<br>• Offer food and drink<br>• Monitor degree of motor block, aim to mobilise (call Physiotherapy) when block fully worn off, pain score 0-1, blood pressure stable<br>• Mobilise with physiotherapy, stand, walk and do stairs ideally in two visits.<br>• Xray AP pelvis at a convenient time for unit<br>• Ensure able to pass urine<br>• Load with analgesia as prescribed, dalteparin at 1400 |
|---|---|

| DISCHARGE | Nurse-led discharge after:<br><br>• Confirmed eating and drinking with no nausea or vomiting (or an acceptable level for patient)<br>• Loaded with oral analgesia<br>• Passed urine<br>• Xray reviewed.<br>• Outreach informed of discharge, written information on analgesia, phone numbers for SOS. |
|---|---|

## How I Do It: Anterior Cruciate Ligament Reconstruction

| **Day Case Anterior Cruciate Ligament Reconstruction (ACLr)**<br><br>Dr Kim Russon, Consultant Anaesthetist, Mr Alex Anderson, Consultant Orthopaedic Surgeon and Kayleigh Wright, Specialist Physiotherapist, Orthopaedics, The Rotherham NHS Foundation Trust | |
|---|---|
| Patient Selection | Default to day surgery for all patients listed for ACLr. No BMI restriction. |
| Pre-procedure | Pre-operative preparation as per any other day case patient. Investigations as pre NICE guidance. Give TRFT patient information leaflet about day case ACLr.<br>**https://www.therotherhamft.nhs.uk/patients-and-visitors/patient-information/ACL-reconstruction** |
| Anaesthetic Technique | PREMED:<br>• Paracetamol 1G<br>• Ibuprofen SR 1600mg<br>• Domperidone 10mg<br>GA or Day case spinal<br>• GA – LMA /iGEL, **s**pontaneously breathing. Maintenance TIVA propofol infusion or sevoflurane.<br>• Spinal – 3mls 2% heavy prilocaine. Inject rapidly. Lie operative side down for 5min**s.**<br>• Analgesia – LA by surgeon +/ adductor canal block (10 - 20mls 0.25% levobupivacaine) Fentanyl 100-200mcg**.**<br>ANTIBIOTICS – Co-amoxiclav 1.2G**.** |
| Surgical Technique | • Standard ACLr surgical technique with dual fixation. 3 port sites.<br>• 80% are hamstring grafts and 20% patella tendon.<br>• TTT 45 - 90min (longer if also includes a meniscal repair).<br>• LA 60mls 0.25% bupivacaine with adrenaline to skin of port sites, skin of harvest site and into knee joint (will need to reduce this if patient small and adductor canal block being given).<br>• Surgeon talks patient through findings that can be seen on screen.<br>• No post-op Xray. |
| Physiotherapy | • Patients not usually seen by physio before surgery.<br>• Communication between DSU and the therapy team on day of surgery when patient is ready for therapy assessment.<br>• Therapy team attend DSC and complete on the bed assessment including: neurovascular assessment, muscle power, range of movement and function. Provide |

| | |
|---|---|
| | patient education (verbal and written) regarding protection of the graft with movement of the knee. Then progress to assessing mobility with elbow crutches – full weight bearing (unless advised otherwise by surgeon). May complete toilet transfers if required but not always necessary as younger patients. Step/Stairs assessment as appropriate.<br>• Patient education prior to discharge:<br>○ Exercise sheet, elbow crutch leaflet<br>○ Advice on ice<br>○ Feedback form for therapy team and also contact information for any problems.<br>• Patient is also given an outpatient appointment with the lower limb team for Physiotherapy approximately 72-hours post discharge. |
| Postoperative care | • Analgesia: Regular paracetamol. Rescue dihydrocodeine or IV fentanyl if severe pain.<br>• DVT prophylaxis – not routinely except if also has a meniscal repair and NWB/PWB then patients receive Aspirin 75mg for 14 days. |
| Take Home Medication | • Regular paracetamol 1G QDS<br>• Dihydrocodeine 30mg QDS<br>• Ibuprofen 400mg TDS |
| Organisational Issues | • OPD Physio 72-hours<br>• Surgeon 6-weeks |
| BADS Recommended Rates | • 90% day case<br>• 10% one-night stay |

## How I Do It: Day Case Laparoscopic Cholecystectomy

<table>
<tr><th colspan="2">Day Case Laparoscopic Cholecystectomy<br><br>Dr Jeremy Preece, Consultant Anaesthetist and Mr David Bunting, Consultant Upper Gastrointestinal Surgeon, Royal Devon University Healthcare NHS Foundation Trust.</th></tr>
<tr><td>Patient Selection</td><td>Standard day case criteria.</td></tr>
<tr><td>Pre-procedure</td><td><ul><li>Morning list if possible</li><li>Standard fasting, Sip Til Send</li><li>Oral paracetamol 1g unless contraindicated</li><li>Oral ibuprofen 400mg if no contraindication</li></ul></td></tr>
<tr><td>Anaesthetic Technique</td><td>General anaesthetic:<ul><li>Ideally TIVA (totally intravenous anaesthesia) but volatile use can be acceptable</li><li>Rocuronium muscle paralysis with Sugammadex reversal if required and guided by neuromuscular monitoring</li><li>Fentanyl: titrated to effect, usually 400-500 mcg but more or less according to clinical judgement</li><li>Dexamethasone: 3.3-6.6 mg IV</li><li>Ondansetron: 4mg IV</li><li>Antibiotics – only if bile spilled, follow local microbiological protocol</li><li>Plasmalyte or other balanced crystalloid solution: 1000ml IV, more if indicated</li><li>Levobupivacaine<ul><li>20ml 0.25% intra-peritoneal via RUQ port prior to gallbladder extraction by surgeon</li><li>20mls 0.5% to port-sites prior to skin closure</li><li>(total dose will require adjustment if patient bodyweight <75kg)</li></ul></li></ul></td></tr>
<tr><td>Surgical Technique</td><td><ul><li>Intermittent pneumatic calf compression for thrombosis prophylaxis</li><li>5mm optical trocar to right upper quadrant or 12mm sub-umbilical port</li><li>1x 12mm epigastric port, 2x 5mm right upper quadrant ports</li><li>Avoid trauma to liver capsule and parietal peritoneum</li><li>Standard dissection with critical view of safety</li><li>Routine intra-operative biliary ultrasound scan</li><li>Double ligation of cystic duct and artery (liga clips or Hem-o-lok clips)</li><li>Gallbladder extraction within bag via epigastrium if optical trocar entry, otherwise via umbilicus</li></ul></td></tr>
<tr><td>Peri-operative Care</td><td>Analgesia</td></tr>
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| | |
|---|---|
| | • Regular Paracetamol 1g PO QDS (even if no pain)<br>• Regular Ibuprofen 400mg PO TDS/QDS (even if no pain) if not contraindicated<br>• Codeine 30-60mg PO 4-hourly prn<br>• Oramorph 10-20mg PO 2-hourly prn<br>• Fentanyl as per recovery protocol<br>Anti-emesis<br>• Ondansetron 4mg PO/IV 6-hourly prn<br>• Cyclizine 25-50mg PO/IV 6-hourly prn (caution in the elderly)<br>• Prochlorperazine 12.5mg IM 12-hourly prn OR Buccastem 3-6mg Buccal 6-hourly prn<br>• Eat and drink when awake<br>• Mobilise freely<br>• No routine pharmacological thrombosis prophylaxis<br>• Nurse-led discharge<br>• No requirement to pass urine prior to discharge |
| Take Home Medication | If no contraindication to NSAIDs:<br>• Paracetamol 1g orally QDS<br>• Ibuprofen 400mg orally TDS<br>• Codeine 30-60mg orally 4-hourly prn (Max 240mg daily)<br>• Lansoprazole 30mg orally OD<br>• Senna 1 to 2 tablets prn |
| BADS Recommended Rates | • 75% day case<br>• 25% one-night stay |

## How I Do It: Day Case Tonsillectomy

| Day Case Tonsillectomy<br><br>Jane Montgomery, Consultant Anaesthetist and Shyam Singham, Associate Specialist ENT Surgeon, South Devon Healthcare NHS Foundation Trust, Torquay | |
|---|---|
| Patient Selection | • Age 3 and over<br>• No sleep apnoea<br>• Within 30 mins drive of hospital<br>• Transport in own car |
| Anaesthetic Techniques | **Clear fluids up to 2hrs pre-operatively**<br>EMLA or Ametop cream.<br><br>Propofol 4mg/kg.<br>Disposable reinforced LMA (a size down from what you would otherwise use) size 2 if < 20kg.<br>Maintenance with isoflurane or sevoflurane in air and oxygen.<br>Spontaneous respiration.<br><br>Dexamethasone 0.25mg/kg.<br>Ondansetron 0.1mg/kg.<br><br>Crystalloids 10ml/kg.<br><br>In recovery free fluids and food on demand. |
| Surgical Technique | Coblation surgical technique to reduce PONV with decreased per-operative bleeding.<br><br>5% lignocaine with penylephrine spray to tonsillar bed at end of surgery. |
| Peri-operative Analgesia | • Rectal diclofenac 1mg/kg<br>• PRor IV paracetamol 20mg/kg<br>• IV Fentanyl 1-2mcg/kg intraoperatively |
| Take Home Medication | • Azithromycin 10mg/kg for 3 days od<br>• Ibuprofen 5-10mg/kg for 1 week qds<br>• Paracetamol 15mg/kg qds for 1 week qds |
| Organisational Issues | • Nursing observations for 6hrs postoperatively.<br>• Nurse led discharge 6hrs postoperatively so need to be on morning list.<br>• Surgeon needs to be contactable in the afternoon if there are any concerns. |
| Common Pitfalls | Site rLMA in anaesthetic room and do not tape to mouth. |

| **Day Case Tonsillectomy**<br><br>Jane Montgomery, Consultant Anaesthetist and Shyam Singham, Associate Specialist ENT Surgeon, South Devon Healthcare NHS Foundation Trust, Torquay | |
|---|---|
| | Check airway patent with head in extension to mimic surgical position.<br><br>Ensure surgeon uses relatively large Doughty blade to avoid compression of rLMA on posterior third of tongue base.<br><br>When gag is put in, if the surgeon can see rLMA cuff it's not far enough in.<br><br>Insertion of gag initially can induce apnoea momentarily - check airway patent with brief bagging.<br><br>If still a problem release gag and put a little tension on the rLMA as it is replaced (may stop rLMA folding on itself). Sometimes the obstruction is relieved when the surgeon places the \Draffin rods.<br><br>If still a problem revert to RAE endotracheal tube. |
| Anticipated Day Case Rates | 70% |

## How I Do It: Day Case Total Hip Replacement (THR)

### Day Case Total Hip Replacement (THR)

Dr Claire Blandford, Consultant Anaesthetist and Mr Mike Kent, Consultant Orthopaedic Surgeon, Torbay & South Devon NHS Foundation Trust, Devon.

| Patient Selection | • Symptomatic hip pathology requiring THR.<br>• Engaged with day case pathway.<br>• No unstable medical co-morbidity requiring in-patient management.<br>• No high dose opioid based analgesia /chronic pain regimen pre-operatively.<br>• Sufficient social support. |
|---|---|
| Pre- Operative Preparation | From booking:<br><br>• Pt counselled to expect DC procedure<br>• Nurse led pre-assessment process completed<br>• Participation in ‘joint-school’ patient education programme – Face to Face education sessions with nursing team and physiotherapist, video presentation, comprehensive information booklet<br><br>On the day:<br><br>• Listed first on theatre list (ideally)<br>• Withhold ACE inhibitor/ A2RB drug on day of and day before surgery<br>• Carbohydrate drink 2hrs pre-op<br>• Pre-medication:<br>  ○ Paracetamol 1g<br>  ○ Ibuprofen 1600mg SR (if not contraindicated)<br>  ○ Oxycodone MR 10mg (5mg dose if age >70) |
| Anaesthetic Technique | • Spinal:<br>  ○ 3 – 3.4ml hyperbaric 2% Prilocaine<br>  ○ NO intrathecal opioid<br>• Sedation:<br>  ○ Aim to minimise/ avoid. If required then low dose Propofol TCI with capnomask.<br>• Local Anaesthesia:<br>  ○ Surgical Infiltration 0.25% levobupivacaine 50mls (40mls if patient weight <60kg)<br>• Antiemetics: (dual agents as standard)<br>  ○ Dexamethasone 6.6mg IV<br>  ○ Ondansetron 4mg IV |
| Intra Operative Care | Goal directed:<br><br>• Normothermia: proactively warm patient with forced air blanket (commence pre-op) & fluid warmer<br>• Normovolaemia: IV fluids 1000-2000mls (warmed)<br>• Blood Conservation: |

| | |
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| | ◦ Tranexamic Acid 1g IV start of case + further 1g at end of case (dose reduced for eGFR<50 and or weight <50kg)<br>◦ Cell salvage collection **<u>routinely</u>**<br>• Antibiotic Regimen:<br>◦ Teicoplanin (slowly in 100mls n/saline) & Gentamicin [weight adjusted doses]<br>• Thromboprophylaxis: mechanical- foot pump used intra-operatively & until mobilisation. Dalteparin 5000units (weight adjusted) sc pre-discharge.<br><br>Key recovery priorities:<br><br>• Manage any PONV aggressively<br>• Commence oral fluids<br>• Fortisip 200ml drink |
| Surgical Technique | General<br><br>• Standard THR as per surgeon's usual technique.<br>• Techniques/implants allow for full weight bearing as soon as feasible.<br><br>Intraoperative<br><br>• Meticulous haemostasis, use of cell salvage, aim to retransfuse if threshold reached.<br>• Infiltration of high volume/low concentration local anaesthetic into surgical field (capsule/released muscles depending on approach/fascia lata/deep dermal).<br>• Abductors/Short External Rotators repaired with non-absorbable transosseous sutures depending on approach<br>• Meticulous multi layer closure with Vicryl absorbable. sutures, Skin closure with moncryl and topical skin glue, Opsite dressing.<br><br>Postoperative<br><br>• Patients mobilised by physiotherapist as soon as ready.<br>• Relaxed dislocation precautions |
| Take Home Medication | • Paracetamol 1g qds<br>• Ibuprofen 400mg-600mg po qds 5/7 (if no contraindication) + PPI cover (Lansoprazole 15mg)<br>• Oxycodone MR 10mg po bd for **5 post op doses** (*5mg if age >70) **with reinforced non continuation of this via discharge summary (automated process**)<br>• <u>THEN step down on Day 3 to:</u> Codeine 30-60mg po qds OR Tramadol 50-100mg qds if codeine intolerant for 3/7.<br>• Ondansetron 4mg po tds 2/7 |

| | |
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| | • Macrogols 1 sachet po bd 5/7<br>• Dalteparin 5000units sc od for 2/7 (+ sharps bin) then step down onto:<br>  ○ Aspirin 150mg po od 28/7<br>  ○ unless other anticoagulation plan in place e.g. warfarin/clopidogrel/ DOAC then usually restart this day 1 post op |
| Post Operative Care | • Patient fulfils all standard day case discharge criteria and demonstrate satisfactory mobilisation/ transfer abilities commensurate with safe discharge.<br>• Check X-ray performed prior to discharge.<br>• Day 1 nurse led telephone call from DSU.<br>• In-house 'orthopaedic outreach' nursing team visit patient in community; days 1,5,10 & 14 to support. Tasks include wound reviews, medication assistance, blood tests/ vital signs monitoring.<br>• Direct telephone access to this service for patients. |
| Organisational Issues | • Theatre listing – patient needs first (or possibly 2nd) slot on a list.<br>• Consider your own facilities/ estate resources to build. your pathway; location of clean air theatres & day case discharge facilities.<br>• Working hours of MDT support staff e.g.: physios may not align with time of patients discharge.<br>• Post-operative support for patients; diverse ways this may be able to be provided. Bespoke solution to your unit may be needed. |
| Common Pitfalls | • Short acting spinal technique required to ensure full offset of sensory/motor block to allow adequate time for mobilisation. If unanticipated complications/ delays occur duration of block may become an issue.<br>• All staff need to be 'on message' so that the patient has confidence in the day case pathway.<br>• First mobilisation hypotension – we have found the 'Fortisip' drink invaluable in reducing this, alongside good hydration and dual antiemetic regimen. |
| Anticipated Day Case Rates | • Not all patients will be suitable for day case management.<br>• Estimates indicate ~30% of waiting list cohort may be DC suitable.<br>• For pre-identified DC patients; successful discharge rates of 90% are achievable. |

## How I Do It: Day Case Trans-Urethral Resection of Prostate

| **Day Case Trans-Urethral Resection of Prostate**<br><br>Mary Stocker, Consultant Anaesthetist and Seamus MacDermott, Consultant Urologist, South Devon Healthcare NHS Foundation Trust, Torquay. | |
|---|---|
| Patient Selection | • Select patients who will cope with catheter at home<br>• Limit to prostates of moderate size |
| Anaesthetic Techniques | • Spinal anaesthetic:<br>  ○ Prilocaine (up to 90 minutes)<br>  ○ 2-Chlorprocaine (if under 1 hr)<br>• Or short acting general anaesthesia<br>• Maintain usual BP |
| Intra-operative care and Surgical Technique | • IV antibiotics at induction<br>• Standard mono-polar TURP<br>• Close attention to haemostasis<br>• 3-way catheter for irrigation if needed<br>• Mobilise after 1-2 hours or spinal block worn off |
| Perioperative Analgesia | • Preoperative: oral paracetamol and ibuprofen<br>• Intra-operative: intravenous fentanyl if spinal not used<br>• Postoperative: regular paracetamol and ibuprofen<br>• Rescue: intravenous fentanyl or oral morphine if required |
| Take Home Medication | • Paracetamol 500 mg po qds<br>• Codeine 30mg po qds<br>• Ibuprofen 400 mg po tds<br>• Laxido 1 sachet bd |
| Organisational Issues | • Catheter removed by district nurse next working day before 10am<br>• Appointment with urology nurses that afternoon after 4pm for symptom check/bladder scan<br>• Notes to urology office to await histology |
| Common Pitfalls | Haematuria may need admission – may be up to10-15%. |
| Anticipated Day Case Rates | 40% |

## How I Do It: Day Case Laparoscopic Hysterectomy

| Day Case Laparoscopic Hysterectomy<br><br>Dr Nuala Campbell, Consultant Anaesthetist and Mr Jonathan Hindley, Consultant Gynaecologist, South Devon Healthcare NHS Foundation Trust. | |
|---|---|
| Patient Selection | • Any woman listed for laparoscopic hysterectomy who fulfills DSU criteria and **desires** day surgery pathway – patient led.<br>• We have tended to avoid women with chronic pain either incidental to or being treated with hysterectomy as we feel that there postoperative pain management is more complex. This is a pragmatic rather than evidence based criterion and is flexible in discussion with patient.<br>• We have avoided women with large (greater than 14 week equivalent) uteruses or other pathology that we feel increase the likelihood of conversion to laparotomy. |
| Anaesthetic Techniques | • Induction and maintenance with target controlled propofol and remifentanyl infusions. Usual maintenance target is about 6 of each.<br>• Intubation and controlled ventilation: I use Pressure Controlled Ventilation- Volume Guaranteed and 5 mmHg of PEEP – this procedure requires a very steep trendelenberg, and this mode keeps barotrauma to a minimum whilst reducing atelectasis.<br>• Large suction beanbag behind shoulders to prevent patient slipping when tipped.<br>• Minimum 3 metre infusion line for TIVA and a tap and extension on the fluid line : arms are tucked to the side and inaccessible during the case.<br>• Always give 1 litre crystalloid as this reduces PONV and dizziness: usually do not need more than this.<br>• IV Dexamethasone 4mg , cyclizine 50mg. Give the cyclizine just before pneumoperitoneum as the tachycardia side effect is useful at this stage!<br>• Subcut fragmin 5000u at end of procedure |
| Surgical Technique | • Standard Total Laparoscopic Hysterectomy with or without removal of ovaries.<br>• Verres entry with high CO2 pressures then operating at 12 to 15mmHg. Three or four port laparoscopy.<br>• RUMI manipulator with balloon colpo-pneumo-occluder and KOH cups to manipulate uterus and maintain pnuemoperitoneum (Have previously used McCartney tubes).<br>• Pedicles secured with bipolar diathermy throughout (reusable instruments). |

| **Day Case Laparoscopic Hysterectomy**<br><br>Dr Nuala Campbell, Consultant Anaesthetist and Mr Jonathan Hindley, Consultant Gynaecologist, South Devon Healthcare NHS Foundation Trust. | |
|---|---|
| | • Vault sutured laparoscopically – needle introduced through 11mm port. |
| Peri-operative Analgesia | • Pre medication with oral Ibuprofen Retard 1600mg and Paracetamol 1G.<br>• Intra operative: IV fentanyl 2 mcg/kg,.<br>• Post operative IV fentanyl, then oramorph and regular paracetamol. |
| Take Home Medication | • Paracetamol 500 mg/ codeine 30mg po qds plus ibuprofen 400 mg po qds |
| Organisational Issues | • Pre operative brief to include PACU staff member as anticipation of individual patient issues hugely valuable in this patient group.<br>• Day Surgical Unit theatre team experienced in major gynaecological laparoscopic cases with skills that enable conversion to open procedures – staff rotate to main theatres if unfamiliar with open cases.<br>• Urinary catheter throughout procedure but removed in theatre prior to reversal of anaesthesia |
| Common Pitfalls | • Fluid redistribution from positioning: warn patient beforehand of periorbital/facial swelling. |
| Anticipated Day Case Rates | • 30 to 40% of benign procedures. Increasing as patient awareness and expectation increases |

## How I Do It: Day Case Vaginal Hysterectomy and Vaginal Repair Surgery

| **Day Case Vaginal Hysterectomy and Vaginal Repair Surgery**<br><br>Dr Mary Stocker, Consultant Anaesthetist and Mr Naru Narayanan, Consultant Gynaecologist Torbay and South Devon NHS Foundation Trust. | |
|---|---|
| Patient Selection | • All women who need surgical treatment of prolapse.<br>• No exceptions.<br>• All surgeons working to the same protocol. |
| Anaesthetic Techniques | General or Spinal Anaesthesia<br><br>General Anaesthesia<br>• Induction and maintenance with target controlled propofol and alfentanil infusions.<br>• Spontaneous ventilation with Laryngeal Mask Airway.<br><br>Spinal Anaesthesia<br>• 3mls 2% hyperbaric prilocaine.<br><br>All Cases<br>• Always give 1 litre crystalloid as this reduces PONV and dizziness: usually do not need more than this.<br>• IV Dexamethasone 6.6mg and ondansetron 4mg iv for hysterectomies.<br>• Anti-emetic medication is not routinely required for vaginal repair surgery.<br>• Subcutaneous fragmin 5000u at end of procedure if >60 minutes. |
| Surgical Technique | • Lithotomy position.<br>• Infiltration with 0.25% Bupivacaine and 1:200000 adrenaline. 20mls per compartment.<br>• If hysterectomy, then I use finger switch diathermy to make incisions.<br>• I ensure meticulous haemostasis.<br>• Mostly 3 pedicle hysterectomy.<br>• If uterine size more than 12 weeks pregnancy size, then I will bisect the uterus after taking the uterine pedicle to make it easier to place a clamp around the cornual pedicles.<br>• No pack and no catheter as routine. |
| Peri-operative Analgesia | • Pre-medication with oral Ibuprofen Retard 1600mg and Paracetamol 1g.<br>• Intra-operative iv fentanyl 25mcg prn. |

| **Day Case Vaginal Hysterectomy and Vaginal Repair Surgery**<br><br>Dr Mary Stocker, Consultant Anaesthetist and Mr Naru Narayanan, Consultant Gynaecologist<br>Torbay and South Devon NHS Foundation Trust. | |
|---|---|
| | • Post-operative iv fentanyl prn, then oramorph and regular paracetamol. |
| Take Home Medication | • Paracetamol 500 mg/ codeine 30mg po qds, laxido 1 sachet bd, plus ibuprofen 400 mg po qds |
| Anticipated Day Case Rates | • > 80% |

## How I Do It: Day case inguinal hernia repair

| **Day case inguinal hernia repair: How we provide a day case inguinal hernia repair service**<br><br>Author: Mr David Bunting<br>Institution: North Devon District Hospital, Barnstaple, UK. | |
|---|---|
| Patient Selection | • Standard day case criteria. |
| Anaesthetic Techniques | • TIVA (Total intravenous Anaesthesia) comprising propofol and fentanyl or sevoflurane if low risk of post-operative nausea and vomiting (PONV).<br>• Intubation or laryngeal mask and IPPV ventilation with air/oxygen only (no nitrous oxide).<br>• Short duration/reversable muscle relaxants<br>• Intravenous fentanyl titrated as necessary (e.g., 250-500mcg).<br>• Routine IV fluids.<br>• Multi-agent anti-emetic use. |
| Surgical Technique | • Standard supine positioning.<br>• Anti-embolism below-knee stockings.<br>• Long-acting local anaesthetic (levobupivacaine) administration making use of maximal safe doses including ilioinguinal and ileohypogastric nerve blocks.<br>• Use of mesh only when defect diameter >12mm. |
| Peri-operative Care | • 'Sip 'till send' oral clear fluids policy to reduce dehydration and PONV.<br>• Peri-operative analgesia utilising a multi-modal approach with, paracetamol, NSAIDS.<br>• Regular post-operative paracetamol and NSAIDS, with judicious use of short-acting opiates.<br>• Early introduction of oral fluids, diet and mobilisation. |
| Take Home Medication | • Regular paracetamol and NSAIDS, with judicious use of short-acting opiates, anti-emetics as required (buccal prochlorperazine 3mg). |
| Organisational Issues | • Admission to dedicated day case ward.<br>• Discharge via dedicated day case ward. |
| Common Pitfalls | • Preventative and post-operative management of nausea and vomiting. |
| Anticipated Day Case Rates | • >90% |

## How I Do It: Day Case Umbilical/periumbilical hernia repair

| **Day Case Umbilical/periumbilical hernia repair: How we provide a day case Umbilical/paraumbilical hernia repair service**<br><br>Author: Mr David Bunting<br>Institution: North Devon District Hospital, Barnstaple, UK. | |
|---|---|
| Patient Selection | • Standard day case criteria. |
| Anaesthetic Techniques | • TIVA (Total intravenous Anaesthesia) comprising propofol and fentanyl or sevoflurane if low risk of post-operative nausea and vomiting (PONV).<br>• Intubation or laryngeal mask and IPPV ventilation with air/oxygen only (no nitrous oxide).<br>• Short-duration muscle relaxants (operative duration can be less than 20 minutes and most don't need relaxation to complete the surgical procedure).<br>• Intravenous fentanyl titrated as necessary (e.g., 250-500mcg).<br>• Routine IV fluids.<br>• Multi-agent anti-emetic use. |
| Surgical Technique | • Standard supine positioning.<br>• Anti-embolism below-knee stockings.<br>• Long-acting local anaesthetic (levobupivacaine) administration making use of maximal safe doses including rectus sheath infiltration.<br>• Use of mesh only when defect diameter >12mm. |
| Peri-operative Care | • 'Sip 'till send' oral clear fluids policy to reduce dehydration and PONV.<br>• Peri-operative analgesia utilising a multi-modal approach with, paracetamol, NSAIDS.<br>• Regular post-operative paracetamol and NSAIDS, with judicious use of short-acting opiates.<br>• Early introduction of oral fluids, diet and mobilisation. |
| Take Home Medication | • Regular paracetamol and NSAIDS, with judicious use of short-acting opiates, anti-emetics as required (buccal prochlorperazine 3mg). |
| Organisational Issues | • Admission to dedicated day case ward.<br>• Discharge via dedicated day case ward. |
| Common Pitfalls | • Preventative and post-operative management of nausea and vomiting. |
| Anticipated Day Case Rates | • >90% |