Planning ambulatory surgery facilities

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Surgery is that branch of the healing art
which teaches the proper use of manual operations
for the preservation or restoration of health,
including such general medicinal and dietetic
treatment as the proper performance
of such operations may render necessary.

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To my brothers and sisters
Virginia Halsey, Evert Douglass,
Marie Wood, Jesse Lee Douglass, and Florence Tritt
for their years of interest and support

REBA DOUGLASS GRUBB

To my husband
John
and to my children
Robert G. Carlson and Merry Lee Laughlin
for their patience and understanding

GERALDINE ONDOV

Foreword

Soon after the Tucson Medical Center Ambulatory Surgery Unit was in operation, representatives from various hospitals and institutions around the country visited our center in anticipation of developing such a facility in their areas. The need for comprehensive written information concerning ambulatory surgery facilities became apparent. In response to this need, the managers of our ambulatory surgery unit, clinical director Mrs. Betty Barnes, R.N., and medical director Dr. Fred Landeen, anesthesiologist, joined me in encouraging Mrs. Reba Grubb, medical writer and education coordinator, and Mrs. Geraldine Ondov, R.N., education coordinator and former operating room director, to collaborate on a comprehensive review and evaluation of various approaches to the planning and development of an ambulatory surgery facility.

Both authors are knowledgeable and experienced in the ambulatory surgery concept. They have participated in the planning, development, and initial operation of the Tucson unit and continue to participate in the educational aspects of the facility.

This carefully researched book spells out the difficulties that might be encountered in a changing service. It incorporates certain concepts that we feel were essential to the overall success of our own unit. Additionally, it throws a practical light on improved services and is intended to synthesize specialized knowledge regarding ambulatory surgery facilities. The authors suggest a basis for workable, effective planning of a facility. The ideas and methods presented may be adapted to the needs of any institution.

I believe that this book, in its presentation of guidelines to planning for the ambulatory surgery facility, will be of great service to medical and surgical staffs, operating room nurses, ancillary personnel, and associated health colleagues. I strongly recommend it as a handy reference for both the beginning and experienced planner of outpatient surgery.

C. Blencowe Daniels, M.H.A.

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Planner and developer of the
Ambulatory Surgery Center

Preface

The trend in hospitals is toward an increase in the number of patients each year. To meet today's challenge and improve the quality of care with decreased cost to the patient, it is important to optimize available resources.

The ambulatory surgery facility is considered a major resource for meeting today's health care challenge. For efficient performance, this facility must be carefully planned, organized, and administered.

This book was written to suggest a framework for planning, developing, and administering an ambulatory surgery facility. It is not possible in a single volume to embody all the details of the planning and management of such a facility that would be equally applicable to every institution.

The information and examples presented in this book were accumulated from the sources available to us. We observed the growth of the Ambulatory Surgery Center, Tucson Medical Center, from an idea to the efficient functioning facility it is today. As a former Tucson Medical Center operating room director, Mrs. Ondov participated in the selection of equipment and instruments for the facility, and with Mrs. Grubb wrote the first procedures for the facility and formulated an orientation manual from information obtained from Mrs. Betty Barnes, director of the Ambulatory Surgery Center, and from personal educational research. We had the privilege of reviewing all written reports and minutes of the ambulatory surgery committee and of the ad hoc planning committees as well as conducting interviews with surgeons from the various specialties, the architects, the administration, the staff of the center, and some of the patients.

The result of research and interviews is a comprehensive overview of planning the ambulatory surgery facility that should be valuable to administrators of health care facilities, architects, operating room and recovery room nurses, ancillary services, hospital consultants, and others interested in expanding outpatient health care services.

The data submitted are arranged in a logical sequence of planning. Policies and procedures that should be included in a manual are found throughout the book in addition to the chapter dealing specifically with writing a manual for the ambulatory surgery facility.

We could not have written the book without the support of Tucson Medical Center's administrative staff, medical and surgical staff, and the ancillary services personnel. We appreciate the courtesy extended to us by the various manufacturers of equipment, instruments, and products for permission to use information and illustrations, which added to the value of the book.

We are indebted to the many friends and colleagues who have offered helpful comments, criticisms, suggestions, and contributions. We also wish to extend our gratitude to the individuals from many disciplines who offered information drawn from their practical experiences: to Donald G. Shropshire, Administrator, and Jerry Freund, Director of Education, from the Tucson Medical Center for their continued interest and support of our projects; to C. Blencowe Daniel, Assistant Administrator, for sharing his knowledge, experience, and collection of Ambulatory Surgery Center planning and building data with us; to Karl Marschinke and Jim Grant of the Purchasing Department; to Debbie Graham, Medical Librarian; and to John McCaffery, Director, Plant Services. We especially acknowledge our contributors, consultants, and the staff of the Ambulatory Surgery Center, Tucson Medical Center.

Reba Douglass Grubb
Geraldine Ondov

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CHAPTER 1

The ambulatory surgery facility concept

Rising costs of hospitalization, shortage of hospital beds, and chronic overcrowding of operating room facilities are influencing factors in the search by hospital administrations for a less expensive method of providing quality surgical care. The ambulatory surgery facility has proved to be the answer for many hospitals. This 1-day surgical service is an innovative method of delivering health care that provides a convenient place for ambulant patient/surgeon contact and a workable approach to quality medical care at a reasonable cost to the patient.

The concept of outpatient care is not new. Galen (131 to 201 AD) describes the "Tabernae Medicae, where only the ambulant sick were treated." On July 3, 1842, Dr. Crawford Long, a country practitioner, administered ether to "Jack, a negro boy belonging to Mrs. Hemphill of Jackson, Georgia" for a toe amputation.[1] Dr. Denslow Lewis, connected with the Chicago Policlinic (1894 to 1898), reported that gynecological patients designated as ambulatory were treated at the clinic. He stated that "It is a hardship in several ways for them (women) to remain in the hospital long enough to convalesce from an operation. They cannot indulge in the 'rest cure' or in many instances, purchase proper food. They seek relief from their ailments without interference with the routine of their daily life." Venereal warts were snipped off with scissors under cocaine anesthesia and the bases touched with carbolic acid. Urethral carbuncles were also removed under cocaine anesthesia. External hemorrhoids were incised, and the clot turned out.[2] More than 7,300 operations, most of them on infants and young children, were performed between 1899 and 1908 in an outpatient clinic of the Glasgow Royal Hospital for Sick Children.[3] In 1938 Herzfeld, surgeon to the Royal Edinburgh Hospital for Sick Children, reported an experience with thousands of cases of hernias in children. Herniotomies were performed on many of the children, who were sent home 2 hours or so after the operation.[4] A policy of operating on infants and children as "day cases" was started in 1949 by Dr. Rex Lawrie at the Evelina Children's Hospital in London and soon became routine there.[5]

The modern concept of ambulatory (also referred to as one-day, short stay, come-and-go, same day, in-and-out, or not-for-admission) surgery was

pioneered in 1961 by Butterworth Hospital of Grand Rapids, Michigan.[6] Since that time, the idea has spread rapidly and many innovations in the handling of ambulatory surgical patients have been advanced. The Come-and-Go Surgery Unit at George Washington University that opened in March 1966 was an early ambulatory surgery program in the United States.[7] The Children's Pavilion of the Winnipeg Health Science Centre has offered day surgery since 1969 and conducts almost 40% of its surgical cases on a not-for-admission basis.[8]

The earliest recognized freestanding surgical centers are the Dudley Street Center in Providence, Rhode Island, founded by Dr. Charles Hill and four associates in December 1968, and the Surgicenter of Phoenix, Arizona, owned by Drs. Wallace Reed and John Ford, which opened in February 1970.[9]

The American Medical Association endorsed the concept of outpatient surgery in 1971 as follows: "Resolved that the American Medical Association endorse the concept of outpatient surgery under general and local anesthesia for selected procedures and selected patients as good medical practice."[10]

For an ambulatory surgery unit to fill a community need, it should meet the following requirements[11]:

1. It must be licensed as a health facility.
2. It must be inspected regularly by an accredited inspection unit such as the Joint Commission on Accreditation of Hospitals.
3. Quality care must be ensured by formal planning and supervised evaluation.
4. It must be a part of the health system and not a further fragmentation of this system.
5. It should maintain a physician/patient relationship.
6. Cost in time and money to the patient must be less than for a similar service in the formal hospital setting.
7. Third-party payers must accept the responsibility of reimbursement at the same level as is customary for this service in the community.
8. The community must accept such a service as one that is needed and desirable.

SETTING

There are at least three primary settings for outpatient surgical care: hospital centered, hospital affiliated, and independently operated.

Hospital-centered setting

In some hospital-centered outpatient surgical units the services are utilized through the emergency room. The patient is admitted to the emergency room and progresses from there to a preanesthesia area, to the operating room, to the recovery room, and is then discharged from the emergency room. In other hospitals the patient is routinely admitted on the day of surgery to a

preoperative area for surgery in the main operating room. In both these instances the burden remains on the operating room. Use of the operating room facilities for minor surgeries often results in frustrations to both patient and surgeon. Minor surgeries are frequently scheduled at odd times and are the first to be rescheduled, or "bumped," for emergencies.

Hospital-affiliated setting*

The hospital-affiliated ambulatory surgical facility may be an annex of the hospital, a separate area within the hospital, or a separate building adjacent to the hospital. It is freestanding,† administered under the rules and regulations of the hospital, and has no overnight beds. Although the facility may be essentially self-sustaining, disciplines within the hospital are available for support or emergencies.

Independently operated setting‡

The independently operated ambulatory facility is freestanding in both cost accounting and structure, with its own rules and regulations. It has no overnight beds. A small laboratory and portable x-ray unit are usually included in this plan. This type of facility should have emergency backup available if it is not adjacent to a hospital.

ORGANIZATION AND BENEFITS

Although the ambulatory surgery facility is based on the same principles as the traditional hospital operating room, there are differences in organization and benefits, as follows:

1. The patient knows in advance what the cost of ambulatory surgery will be and is able to plan ahead for this important consideration. Separate cost accounting and efficiency of operation permit the facility to achieve a balanced budget, as opposed to the operating room budget, which may or may not balance.
2. Planned and scheduled elective surgery, performed on low-risk patients, allows for full utilization of the ambulatory surgery facility by surgeons. It is also timesaving, since there is no necessity for the surgeon to follow the patient's progress within the hospital.
3. The hospital is relieved of the heavy inpatient load of minor surgical patients who do not need to stay overnight. The price of the hospital room per day is eliminated, resulting in a cost savings to the insurance carrier as well as to the patient.
4. Risks of hospital-associated (nosocomial) infections are minimized,

*An example is the Ambulatory Surgery Center of the Tucson Medical Center, Tucson, Arizona.
†Freestanding refers to cost accounting and not necessarily physical structure.
‡An example is the Surgicenter, Phoenix, Arizona.