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CURRENT PROBLEM

Day case treatment for children

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Treating children as day cases has been a familiar task for paediatricians[1] and most surgeons[2] for more than two decades. Born of a mixture of humanitarianism and expediency, day care is now encouraged by the Department of Health because of its perceived value for money.[3] Unfortunately, it is not invariably good value for child and parent, particularly as services have developed piecemeal and frequently depend more on the enthusiasm and energy of particular people than on any formal management plan.

Caring for Children in the Health Services (CCHS),* a working group that includes purchasers, providers, and consumers, has published its fourth report; this deals with day care and is entitled *Just for the Day*.[4] Numerous people and organisations were invited to give evidence, including Royal Colleges, professional and voluntary organisations, health authorities, hospitals, and parents. The findings are best introduced by the words of a consumer:

'A 3 year old was booked in as a day case for circumcision. The only preparation he or his parents received was a map of the hospital, an out of date guide to the children's ward (obviously designed for long stay inpatients), and instructions on overnight fasting. On arrival he was put to bed in a general paediatric surgical ward where the staff seemed to his mother to be far too busy with ill children to give him much of their time; nobody could predict when he would be going to theatre and his mother was not permitted to carry him or wheel him there, or to accompany him into the anaesthetic room. He was frightened by being transported on an adult sized trolley by two figures in theatre dress.

By the time of operation he had been starved for 14 hours and had been pleading incessantly for a drink. Left at the theatre door his mother was not told where she might wait, when her son would be returned to the ward, or whether she could obtain refreshments for herself. Like many mothers she had starved vicariously with her child.

He seemed comfortable when he returned but later attempts by his mother to obtain analgesia were met with the comment that nothing had been written up and the doctors were all in theatre. At 9 pm a nurse approached, seemed surprised to see them and said: "What are you doing here? You should have gone home hours ago" '.

The hospital concerned is a major teaching unit but complaints of this sort came from parents who had been dealt with in various hospitals which had in common only the lack of any coherent planning for day services.

The CCHS survey was not designed to report on current practice but the enormous bulk of information that was received allowed a reasonable assessment of what is happening. There are hospitals where the anecdote described above would be a most unlikely occurrence. In general these hospitals contain day units that were initiated and are sustained by enthusiasts with a designated director, often a nurse, acting within clear management policies.

In many hospitals, however, there are no special day case facilities for children, who are cared for together with adults without regard for their individual needs; day patients and inpatients are inappropriately mixed, clerical staff are few, and child day patients are rarely separately monitored and audited. Perhaps because of this there is often little thought given to these children as a discrete group: inadequate information for parents, non-existent operational policies, and too frequent admission overnight are some of the results.

Just for the Day aims to provide a managerial tool for hospitals to enable them to provide a quality of care equal to the best day units.[4] The result is a comprehensive set of standards, including principles for preadmission, transfer of care, and care in the community after discharge.

Day case investigation and treatment are an integral part of the philosophy that demands that separation of child from home and family should be kept to a minimum, that parents take part in decision making, and that they are made welcome in our hospitals. Despite the reluctance of some to change their style of practice the increasing proportion of day case treatment is evident. The Royal College of Surgeons of England has published guidelines to encourage surgeons and health authorities and trusts to undertake more day surgery.[5]

The CCHS has found that the increase in the amount of day surgery is much more apparent in adults than children; the report does not speculate on the reasons but one might easily be the greater pressure on adult inpatient beds as a result of financial squeeze. Of the district general hospitals offering evidence, one undertook 80% of its waiting list admissions as day cases and there is well documented information that more than half of all the general surgery of childhood can be carried out safely in this way.[6]

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*Caring for children in the health services, 7 Belgrave Place, Clifton, Bristol BS8 3DD, represents: the Royal College of Nursing, the National Association of Health Authorities and Trusts, the National Association for the Welfare of Children in Hospital, and the British Paediatric Association. Co-opted were the British Association of Paediatric Surgeons, the Association of Anaesthetists of Great Britain and Ireland, and the College of Anaesthetists.

Yet, in many health districts, the figure is below 10%. An Audit Commission survey of 54 districts found that the day cases were 29·3% of hernia repairs, 17·4% of circumcisions, 55·4% of myringotomies, and 2·7% of squint corrections.[4]

It is too early to predict the effect on day surgery of the recommendations of the National Confidential Enquiry into Perioperative Deaths (NCEPOD), but one of them was that surgeons and anaesthetists should not undertake occasional paediatric practice and that consultants who care for children must keep up to date and competent in their management.[7] In district hospitals without paediatric surgeons this might usefully lead to an agreement whereby a particular surgical and anaesthetic team took major responsibility for operating on children. CCHS welcomed the setting up in 1990 of the British Association of Day Surgery the aim of which is to promote high standards throughout the United Kingdom.

So far as non-surgical day care is concerned, the national performance indicators for medical paediatrics show an average for day cases of only 2%, which tells us a lot more about the collection of data than it does about how paediatricians work.[8] The confusion between 'ward attenders' and day cases has been highlighted previously by the CCHS.[9] Many paediatric units are still careless over the keeping of these statistics, especially where resource management has made little impact. If the Department of Health is to have any inkling about the nature of paediatrics in hospitals it is vital that what goes on in children's wards is thoroughly documented and reported.

After assessing the information it received the CCHS recommended 12 quality standards for a planned package for day care that should be used in NHS contracts:

(i) The admission is planned in an integrated way to include preadmission, day of admission, and postadmission care, and to incorporate the concept of a planned transfer of care to primary or community services, or both.

(ii) The child and parent are offered preparation both before and during the day.

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

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

(v) The child is neither admitted nor treated with adults.

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

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

(viii) 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.

(ix) The building, equipment, and furnishings comply with safety standards for children.

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

(xi) Essential documentation, including communication with the primary and community services, is completed before each child goes home so that aftercare and follow up consultations are not delayed.

(xii) 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.

So that they can monitor providers' compliance with these standards, purchasers are enjoined by the CCHS to identify data from which children can be audited separately, day cases can be separated from inpatients, rates of transfer to inpatient care reviewed, children's and parents' opinions sought, and the effectiveness of integration of hospital and community services can be analysed.

Providers are also offered advice; for surgeons this is based on the Royal College of Surgeons of England's specially commissioned report, which has been updated by discussion with other professional bodies representing surgical and anaesthetic interests. It includes a list of procedures suitable to be done as day cases, and reminds clinicians of the American Society of Anesthesiology classification for patients requiring general anaesthetic. Special note is made of premature babies who are still only a few weeks past their full term age, or who have a history of ventilatory support.

There have been no similar published quidelines for medical paediatrics so the CCHS has taken evidence from all the subspecialties and devised a practical list. This includes tolerance tests, jejunal biopsy, endoscopy, imaging under anaesthesia, setting up or giving intravenous treatment, as well as multipurpose day admissions to undertake clinical measurements, investigations and discussion with parents and child—for example, in cystic fibrosis, cancer, or newly diagnosed diabetes mellitus.

Of course not all families can take advantage of day care facilities. A parent will usually need to stay throughout the day and will need to provide suitable transport, which certainly does not mean public transport, after the procedure. The adequacy of facilities at home need to be taken into account before booking a child as a day case.

A major problem, especially where there are entrenched views or where capital and space are in short supply, is where precisely to locate a children's service. In *Just for the Day* this is discussed, and various models are described as well as the ideal. It is best if children are kept together in a purpose designed day unit close to the operating theatres or with its own integral theatre and recovery facilities. An alternative, widely practised at present, is to base children on a general children's ward. This has disadvantages, which were made clear by many of the respondents to the CCHS inquiry; both staff and parents report the danger of day cases becoming 'second class' or 'lodgers' because they are not given a high priority compared with inpatients who may be more ill. There is

unquestionably a greater chance of the admission continuing overnight when the unit is not specifically designed for day care.

Where management on the ward is unavoidable, a reasonable compromise would be to provide a separate area of the ward dedicated to day cases who are then nursed by designated staff without other duties. It might even be practical for it to double as overnight parental accommodation. Of course, if the ward is a long way from the operating theatres this may simply not be feasible.

An alternative might be to provide a children's day room for medical procedures (and perhaps endoscopy) both for day patients and ward attenders. Under these conditions surgical day care would be carried out on an adult or mixed day unit. This option will not appeal to paediatricians, paediatric nurses, and managers of children's services who are likely to feel that the environment, staffing, and facilities will not meet national recommendations.[10–12]

If such a system is unavoidable there may be ways around the problem: for example, an occasional or periodic children's list can be built up so that, for that particular session, the unit is used for children only. Successful adoption of this system was reported to the CCHS from Exeter and Winchester. At Kingston and Colchester small groups of children were admitted to a special room where they could be active preoperatively, and recover postoperatively, separately from adults in the unit.

Clinical directors must consider how day units should be staffed. Day cases pose a particular problem for junior medical staff who can be forgiven for seeing them as having a lower priority than some of their other patients, but the demands are great and time is short when dealing with such children and their families. These doctors deserve a formal, explicit statement of their duties in this respect. There should be distinct nursing staff; it is likely that there are a considerable number of registered sick children's nurses or others trained and experienced in the care of sick children who are not currently employed in the NHS but prepared to return to a flexible part time job. An administrator, who may be from a clerical or nursing background, is essential.

A day should be as short as possible. Vessey *et al* have pointed out that being asked to arrive too early provokes a period of great stress, with an irritable, hungry, and apprehensive child (and mother).[13] Stepped appointment times offer better quality of care but anaesthetists and surgeons have told the CCHS that with current staffing levels and intensive theatre use such a system may not be practicable. Despite this, issues must be discussed among surgeons, anaesthetists, and nurses so that the reasoning is clear to all. The sort of questions that arise are, for example: Would parents be willing and able to wake a child at 6 am for a drink to cut down starvation time? Would it be preferable to have children on an early afternoon list so that they can have breakfast? Should babies be at the beginning of the list to avoid dehydration or in the middle so that they can have an early morning feed?

Many units have provided leaflets and information sheets for parents and children. Some are well worth plagiarising—that from Southampton, for example. With the more complex consent forms now coming into use, documentation will take even longer. Surgeons who do not already do so might consider obtaining informed consent at the time of the outpatient visit that precedes the booking.

In *Just for the Day* evidence from a wide range of sources has been sifted through a group close to where the work is done. Because of this it deserves wide circulation; paediatricians and surgeons who wish to set up day case services or audit their current practice can do no better than to use it as a working document.The CCHS has produced a statement summing up the principles it sees as most important in developing policies. For those of us instructed to prepare a 'philosophy' or 'mission statement' it is readymade.

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 so 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 and 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 effective communication between the hospital and primary/community support team.

The planning and delivery of care should recognise the multicultural nature and diverse needs of the population and provision should be made accordingly.

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